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MENTAL DISEASE AND DELINQUENCY

A REPORT OF A SPECIAL COMMITTEE OF THE NEW YORK STATE COMMISSION OF PRISONS*

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INTRODUCTION

THE price paid by society for its neglect of the criminal has never been adequately estimated. Neither in dollars and cents nor in sorrow and cost of wasted and frequently vicious lives has half the story ever been told.

An enormous financial burden is carried by every state of the Union in its fight against crime. State and city budgets give startling evidence of the vast expense which criminality is to society, this being understood to be the largest single item in the public budget. To illustrate:

The cost of the detention, indictment, trial or other disposition of the average felon is conservatively estimated at $1,000. On

*At a meeting of the New York State Commission of Prisons, held June 4, 1918, a resolution was adopted, directing that an investigation be made on the subject of mental disease and delinquency, by a committee of the Commission. In accordance with this resolution, a committee was appointed consisting of Hon. Frank E. Wade, Hon. John S. Kennedy, Hon. Sarah L. Davenport, Hon. Allan I. Holloway and Hon. George W. Davids. This committee, assisted by Dr. V. V. Anderson, formerly Medical Director of the Municipal Court of Boston, made a state-wide investigation as directed, into conditions in the penal and correctional institutions, and into the clinical work connected with the courts, taking the testimony of judges, medical experts, psychiatrists and others, and collecting available data and statistics of the mental examinations of prisoners and delinquents in this and other states. This report sets forth the findings of the committee together with its recommendations to the State Commission of Prisons.

this basis, the 2,279 felons received into the state prisons during the year 1917, cost the state approximately $2,279,000. Of these individuals 87 per cent had served previous terms and by their release into the community and return to criminal habits the state spent approximately two million dollars to dispose of them again and it continues to spend that amount each time it undertakes to convict this particular group of repeaters. Nothing can be accomplished in the way of permanent good for all this expenditure, if the criminal has not been deterred from repeating his criminal acts.

New York State in 1917 received into its penal and correctional institutions 133,047 prisoners, 60 per cent of whom had served previous commitments.

Massachusetts in a given year received into its institutions 25,820 prisoners, 57.4 per cent of whom were repeaters; the total number of previous commitments being 92,443, averaging six sentences for each recidivist.

Justice Rhodes of England, writing in the *British Medical Journal*, asks, what can it mean that of 180,000 convictions in a given year, more than 10,000 have been convicted upwards of twenty times before.

Wherever our investigations have led us, the startling and depressing facts of recidivism stand out as a proof of the complete breaking down of the social security furnished by the state, in that it has failed to repress crime through the rehabilitation and readjustment of the criminal.

A most hopeful feature of the whole situation, however, is the widespread interest shown in the entire subject, and the existence of powerful forces bearing in from all sides, tending to greater enlightenment upon the problems of crime. Whether these forces have come from law or medicine, or psychology, or social or public agencies, they have all contributed to a better understanding of the criminal and the problem he presents.

Facts of unquestioned value are already at hand which go far toward explaining many past failures in readjusting the criminal. In New York State, reports coming from the State Reformatory at Elmira, the State Reformatory for Women at Bedford Hills, and Auburn and Sing Sing Prisons, speak in no uncertain terms of conditions found with such a high degree of frequency among prisoners, particularly among recidivists, as to make clear a definite relationship between delinquency and mental disease and defect.

Dr. Bernard Glueck, in the first annual report of the Psychiatric Clinic in collaboration with Sing Sing Prison, states that "of 608 adult prisoners studied by psychiatric methods out of an uninterrupted series of 683 cases admitted to Sing Sing Prison within a period of nine months, 66.8 per cent were not merely prisoners but individuals who had shown throughout life a tendency to behave in a manner at variance with the behavior of the average normal person, and this deviation from normal behavior had repeatedly manifested itself in a criminal act." Further, "Of the same series of 608 cases, 59 per cent were classifiable in terms of deviation from average normal mental health. Of the same series of cases 28.1 per cent possessed a degree of intelligence equivalent to that of the average American child of twelve years or under."

Such findings confirm similar reports coming from prisons, reformatories and courts throughout the country as indicated in the tables which follow:

Table I—Inmates of Prisons Exhibiting Nervous or Mental Abnormality

Institution	*Authority*	*Number of cases studied*	*Percentage found to have nervous or mental abnormalities*
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	459	61.7
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	608	59.0
Indiana State Prison	Dr. Paul E. Bowers	100	45.0
Massachusetts State Prison	Dr. A. Warren Stearns and C. C. Rossy	300	34.9

From this table it is seen that at least 50 per cent of the inmates of state prisons are suffering from some form of nervous or mental disease or defect.

Table II—Inmates of Reformatories and Houses of Correction Exhibiting Nervous or Mental Abnormalities

Institution	*Authority*	*Number of cases studied*	*Percentage found with nervous or mental abnormalities*
N. Y. State Reformatory, Elmira	Drs. Frank L. Christian and John R. Harding	400	58.0
Mass. State Reformatory (for men)	Dr. Guy G. Fernald	1,376	59.0
Mass. State Reformatory (for women)	Dr. Edith R. Spaulding	500	63.0
House of Correction of Holmsburg, Pa.	Dr. Louise S. Bryant	100	69.0
Western House of Refuge for Women, Albion, N. Y.	Dr. Jessie L. Herrick	185	82.1
Westchester County Penitentiary	Dr. Bernard Glueck	225	57.0
Massachusetts Reformatory (women)	Jessie D. Hodder	*5,310	72.2

* Women criminals of Massachusetts either on probation or sentenced to institutions, 1915.

The foregoing figures show not only the number of persons with intellectual defect but include cases of insanity, epilepsy, psychopathic personality, drug deterioration, alcoholic deterioration and other abnormal nervous and mental conditions, all of which seriously handicap the individual in his ability to adjust himself to the conditions of normal living. All of these mental conditions are most important in considering any real constructive attempt at rehabilitating the criminal.

One of the most important, if not the most important group of which society needs to take cognizance, is the feebleminded. The feebleminded furnish the substantial nucleus of that most expensive body of individuals who clog the machinery of justice, who spend their lives in and out of penal institutions and furnish data for the astonishing facts of recidivism—facts which are serving to awaken our social conscience to the need of more adequate treatment under the law for repeated offenders. It is of this group that Dr. Walter E. Fernald has so well said: "Feeblemindedness is the mother of crime, pauperism and degeneracy. It is certain that the feebleminded and their progeny constitute one of the great social and economic burdens of modern times."

The following tables, showing the percentage of inmates of prisons, reformatories and other correctional institutions, that are feebleminded, are most significant.

Table III—Inmates of State Prisons Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	608	21.8
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	459	35.6
Mass. State Prison (men)	Dr. A. W. Stearns and C. C. Rossy	300	22.0
Joliet Penitentiary (Ill.)	Louise and George Ordahl	*49	28.5
Auburn Prison (women)	Mabel R. Fernald, Ph.D.	*76	25.0
Indiana State Prison	Dr. Paul E. Bowers	100	23.0
San Quentin (Cal.)		150	30.7

Of the inmates in prisons throughout the country, where studies have been made, 27.5 per cent are found to be feebleminded.

Table IV—Inmates of Reformatories Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
N. Y. State Reformatory for Women, Bedford Hills	Social Hygiene Laboratory	335	31.9
Massachusetts Reformatory	Dr. Guy G. Fernald	1,376	20.2
Massachusetts Reformatory for Women	Dr. Edith R. Spaulding	500	16–45
Western House of Refuge for Women, Albion	Dr. Jessie L. Herrick	185	33.5

*Women.

Table V—Inmates of Penitentiaries and Workhouses Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
N. Y. County Penitentiary	Mabel R. Fernald, Ph.D.	106	26.6
N. Y. City Workhouse (Blackwell's Island)	Mabel R. Fernald, Ph.D.	95	42.7
Westchester County Penitentiary (N. Y.)	Dr. Bernard Glueck	225	33.0
Columbus, Ohio, Workhouse	A. R. Gilliard	100	33.0

Table VI—Inmates of Industrial Training Schools Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage found feebleminded*
Berkshire Industrial Farm (boys)	Dr. Clinton P. McCord	150	11-35
State Training School of California (boys)	J. Howell Williams	215	32.0
State Training School for Girls (Ill.)	Louise and Geo. Ordahl	432	22.0
Preston School of Industry, Ione, Cal.	Fred H. Allen	382	36.4
State Industrial School for Girls, Cal.	Ada C. Bowler	75	34.0
State Training School for Girls, Hudson, New York	Edna G. Bridgeford	...	50.0

From the foregoing tables it is seen that 31.4 per cent of inmates of reformatories, training schools, workhouses and penitentiaries are found to be feebleminded.

It is clear from Tables I and II that within the prisons, reformatories, penitentiaries and workhouses throughout the country there is found a large group of prisoners who exhibit nervous and mental abnormalities, who are mentally crippled or mentally ill. Fifty per cent of the inmates of these institutions require much more specialized and much more individualized treatment than is afforded by the ordinary routine methods employed in the average penal institution. This is not a sentimental consideration but a practical measure looking toward social security. Laying aside the humane element involved, the paramount interests of society are jeopardized if we ignore the well known facts of individual differences.

In Tables III, IV, V and VI this point is illustrated. Feebleminded delinquents, as the foregoing tables will show, comprise from 27 to 29 per cent of the inmates of penal and correctional institutions throughout the country. Just what sort of a problem the seriously delinquent feebleminded person may present is seen

from the following study undertaken in connection with the Municipal Court of Boston:

The careers of 100 feebleminded delinquents were intensively studied; the case histories were taken from the court files alphabetically, no other selection being required than that each individual should have been diagnosed feebleminded. The 100 persons in this particular group were arrested 1,825 times; record cards dating further back than five years were not gone into though many of the hundred had had earlier court records.

The futility of employing for this group measures intended for those capable of profiting by experience is shown from the following facts:

These delinquents in court were discharged after short periods of detention or judicial reprimand a great many times but they returned with unfailing certainty to be handled over again. They were placed on probation 432 times, but had to be placed on inside probation, that is, within institutions non-penal in character, 118 times. Of the remaining probationary periods, 220 were unsuccessful, the individuals again having to be surrendered to the court, making in all not quite one successful probationary period for each of these 100 individuals. The chances were better than four to one against any one of these individuals conducting himself normally for a six months' probationary period.

The court, in addition to probation for these individuals, tried penal treatment. They were sentenced 735 times, their sentences aggregating in fixed time 106 years' imprisonment, exclusive of 250 indeterminate sentences to the reformatories. But this did not in any way suffice to change the course of their careers.

Finally as an explanation of all this maladjustment, examination disclosed that none of these 100 persons possessed a degree of intelligence above that of the average American child of 12 years. About 75 per cent had the mental level of children under 10 years. Investigation into the past histories disclosed the astounding fact that 75 per cent had never been legitimately self-supporting. Worst of all, so far as society's responsibility is concerned, 73 per cent of these persons, though having ample opportunities for common-school education, beginning school at the usual age and leaving at the age of 14, 15 and 16 years, were never able to get beyond the fifth grade in school.

How much more profitable would it have been if the condition from which these persons were suffering had been recognized

during the school period when a chance existed in each and every case either for some advance along the lines of proper habit-training, thereby saving much economic waste, protecting society as well as these individuals themselves from their weaknesses and making them useful members of the community, or for placing them in a limited environment suited to their special needs!

So far in this report we have endeavored to emphasize two things:

1. That the recidivist is the real problem in the prevention of crime; in him we have failed to accomplish that which we set out to achieve.

2. That an important and probably the most important underlying causative factor in this failure to profit by such experience is the defective mentality by which the recidivist is so commonly handicapped. In this connection recent studies* made of a group of 100 immoral women and a group of 100 drunken women showed that among the immoral women 39 per cent of first offenders, 47 per cent of second offenders and 84 per cent of recidivists were suffering from some form of mental or nervous handicap; that among drunken women 35.4 per cent of first offenders and 82.2 per cent of recidivists exhibited some nervous or mental abnormality. The relation between the mental condition of these persons and the frequency of their offense is obvious.

SITUATION IN NEW YORK STATE

Table VII—Percentage of Inmates of Certain New York Penal and Reformatory Institutions Exhibiting Nervous and Mental Abnormalities

Institution	*Authority*	*Percentage exhibiting nervous and mental abnormalities*
Sing Sing Prison	Dr. Bernard Glueck	59.0
Auburn Prison	Dr. Frank L. Heacox	61.7
Clinton Prison	Dr. V. V. Anderson	60.0
Auburn State Prison (for women)	Mabel R. Fernald, Ph.D.	25.0†
Westchester County Penitentiary	Dr. Bernard Glueck	57.0
New York State Reformatory	Dr. Frank L. Christian and Dr. John R. Harding	58.0
New York State Reformatory for Women,	Mabel R. Fernald, Ph. D.	31.9†

The existence of mental disease and deterioration, intellectual defect, psychopathic personality, epilepsy and the like, in a fairly

*V. V. Anderson, M.D., and Christine M. Leonard, M.D. The Immoral Woman as Seen in Court: a Preliminary Report. *Boston Medical and Surgical Journal*, 177: 899–903, December 27, 1917. Drunkenness as Seen Among Women in Court. MENTAL HYGIENE, 3: 266–74, April, 1919.

†Feebleminded.

large proportion of the inmates of these institutions makes clear and obvious how futile it is merely to go on blindly administering the law instead of endeavoring to solve the problems these individuals present. A similar situation in the treatment of disease would consist in sending all sick persons regardless of their disease to hospitals to be given the same treatment, fixing in advance the length of time they were to remain there and at the end of this arbitrary period sending them out without any reference to whether they were well or not. Are we not following the same lines in locking up criminals and then turning them out, and then locking them up and turning them out again, without any reference to whether our purpose in locking them up has been attained; or whether they are any better fitted to assume their normal relation to society on the day they leave prison than they were the day they entered it?

Even where scientific studies and classifications have been undertaken, if these have not been made the basis for treatment, nothing in the way of benefit to the individual or security to society can be said to have been accomplished by such investigations. The mere knowledge of the existence of these conditions, the mere labeling of a certain number of prisoners as intellectually defective or mentally diseased or deteriorated, or psychopathic, is not enough. Such knowledge should be made the basis for treatment. Constructive efforts should be made to rehabilitate these persons in the light of the needs of each individual prisoner, not only of his disabilities, but of his capabilities and his adaptabilities. The machinery of the penal institutions should be so organized as to enable it to carry into effect such recommendations as would be suggested.

But as indicated from the foregoing tables, such a heterogeneous group as is to be found in all penal institutions, composed as it is of types requiring entirely different lines of treatment, would preclude the possibility of carrying out this program in every one of the units of a penal system in a great state like New York; therefore, those who have given thoughtful consideration to the problem feel that the situation could be handled best by establishing clearing houses with medical clinics, through which would pass all prisoners sentenced to prison and reformatory institutions.

CLEARING HOUSE AT SING SING

Every sentenced male felon first should be admitted to the clearing house now being provided at Sing Sing Prison. Here he

should be kept under observation for a period of three or four months, studied physically and mentally, given the very best in the way of modern medical treatment, and placed under intensive vocational study and training for as long a period of time as necessary to enable the administration to define clearly the problem which he presents. Soon after his admission he should be presented at the medical clinic for a rigid and thoroughgoing physical and mental examination. The most approved clinical and laboratory facilities known to modern medicine should be used in these examinations. The aim should be not only the physical rehabilitation of the prisoner and the delineation of those underlying causative factors responsible for his delinquent career, but an effort should be made also to discover the abilities of each prisoner in order to determine whatever qualities he may possess, the cultivation of which might enable the penal administration to restore him to his normal relation to society as promptly and as permanently as possible.

Undoubtedly many criminal careers are due less to inherent biological defects in make-up than to the repeated exposure throughout life to unfavorable environmental and developmental conditions, forming in this way many of the character traits and personality difficulties so commonly responsible for delinquent behavior.

The most important phase, therefore, of the examination at the clinics would be a study of the personality and life history of the individual. While psychological tests would necessarily be given, since a cross-section view is most helpful, nevertheless the greatest emphasis should be placed on the careers of these individuals as seen in the light of modern psychiatric knowledge of behavior.

It is no doubt needless to add that, inasmuch as the very nature and purpose of this clearing house would be essentially medical, all its clinical activities should be under medical direction. Further, it may be well to emphasize that no one phase of the work such as sociological, psychological, psychiatric and physical should constitute an independent unit, if anything like a well rounded study and an intelligent and understanding treatment of each individual is the aim. Only by making each one of these various aspects a coordinate part of a comprehensive scheme in the study and treatment of each and every individual prisoner, can successful results be obtained.

As stated before, the average length of sojourn at the reception

prison would be three or four months; some would not require so long a period, while in other cases a clear definition of the problem presented would necessitate a much longer period than three or four months. After this period of examination it would be possible to supply to other prisons "a stream of healthy, sane, able-bodied prisoners" who have received treatment for physical defects and disease, whose mental condition has greatly improved and who by intensive vocational study and training, would be able to acquire in other prisons skill in that trade or occupation best suited to their abilities. Those discharged from the clearing house should be distributed to the other prisons in the following manner:

1. All cases of tuberculosis should be transferred to the tuberculosis hospital at Clinton Prison.

2. Those sentenced to the reformatory at Elmira would be transferred to that institution. This in no way would interfere with the power of the court to commit to Elmira, as only the insane and those of the defective delinquent group, requiring very special care and treatment would be transferred elsewhere.

3. The younger and more normal male felons receiving state prison sentences should be transferred, as Dr. Glueck has said, "after having been well started in acquiring the trade for which they are best suited, as determined by scientific inquiry into their capabilities," to either one of the two industrial prisons of the state, Clinton or Auburn.

4. The older normal prisoners and those found incapable of learning a trade should be transferred to the agricultural prisons, Great Meadow and Wingdale, where they could make themselves most useful to the state in some form of agricultural occupations.

5. The insane who require treatment of a more or less permanent nature in hospitals for the insane should be transferred to the Dannemora State Hospital for the Criminal Insane. The more recoverable types should remain at the reception prison under proper treatment in a specially constructed pavilion.

6. There remains a very large group known as the defective delinquent group. The term "defective delinquent" is used here in a sense similar to that in which the term "insane" is used, being more of a legal than a strictly medical classification. In this group are included the intellectually defective delinquent, the psychopathic delinquents, the epileptic delinquents and the like. The individuals belonging to this group, who after pro-

longed and careful study and training are found incapable of reconstruction to a degree which would justify their release into the general community, should be committed to an institution specially suited to their particular needs, an institution for defective delinquents.

As the following table indicates, about 15 to 20 per cent of prison and reformatory inmates may well be segregated in such an institution.

Table VIII—Percentage of Inmates in Certain Prisons and Reformatories Regarded as Segregable

Institution	*Authority*	*Percentage regarded as segregable*
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	17.9
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	15–25
New York State Reformatory (Elmira)	Dr. Frank L. Christian and Dr. John R. Harding	17.0
San Quentin Prison (California)	Report of San Quentin Prison	17.9
Massachusetts Reformatory for Men	Dr. Guy G. Fernald	15.5
Massachusetts Reformatory for Women	Dr. Edith R. Spaulding	24.8

The more adjustable members of this "defective delinquent" group who show capacity for reconstruction to a degree that would justify their later release into the community under close and intensive supervision should be retained at the reception prison for prolonged training as a special group and later transferred to the industrial and agricultural prisons for further training. The intellectually defective members of this group, not regarded committable to the institution for defective delinquents, who may have slight difficulties of personality, may furnish little trouble and may well be made self-supporting and later restored through intelligent parole to the community. The psychopathic members of the defective delinquent group, the neurotic, unstable, emotional, temperamental individuals suffering from serious difficulties of personality, furnish a problem far less easily solved. Those who do not break down completely under confinement and require treatment as insane, those who do not have to be committed to the institution for the defective delinquents, may be given the advantages afforded by prolonged training and may well, through the education of their inhibitions, learn to control their impulsive tendencies and emotional outbreaks to such a degree as to enable them later to be incorporated into the community, achieving more or less enduring adaptation to their

industrial environment and protected from the stresses and temptations to relapse by adequate social supervision.

It would be like elaborating the obvious to call attention to the close relationship such a program bears to a real indeterminate sentence.

It is generally accepted that but for the defective delinquent group the punishment problem would almost disappear in prisons; that these individuals are the source of all disciplinary measures required. It is quite evident then that proper classification would not only be of immense value in this direction, but, what is of the greatest importance to the prison management, it would enable those agencies already existing in prisons, such as self-government, education, industrial training, etc., to be used more effectively.

CLEARING HOUSE AT BEDFORD HILLS

All that has been said relating to the need of a clearing house for the sentenced male felons of New York State may be restated with equal, if not greater, emphasis in regard to the female inmates of the state penal and correctional institutions.

The well recognized menace that venereal disease is to the general public and the high frequency of those conditions found among delinquent women are matters for serious consideration. In 440 cases studied at the New York State Reformatory for Women at Bedford Hills, 48 per cent gave positive reactions to the Wassermann test for syphilis. Of 289 prostitutes studied by the Baltimore Vice Commission, 63.7 per cent showed syphilis. At the Reformatory for Women at Framingham, Massachusetts, 75 per cent of the population were suffering from gonorrhea. At the New York Reformatory for Women at Bedford Hills 73 per cent showed the presence of gonorrhea.

The relationship that these two conditions bear to feeblemindedness need not be enlarged upon here. Venereal disease and feeblemindedness form a combination as productive of human wretchedness and misery as any scourge that has ever afflicted mankind. Twenty-three per cent of the women at the Reformatory at Framingham, Massachusetts, who were fit subjects for permanent segregation on account of mental defect, showed 90 per cent of gonorrhea and 60 per cent of syphilis.

At least 30 per cent of the population in representative penal institutions for women in New York State are feebleminded, as indicated in Table IX. No satisfactory figures were obtainable

showing how large a number of the women prisoners were suffering from other pathological, nervous and mental conditions, such as mental disease or deterioration, psychopathic personality, epilepsy and the like. However, the high percentage of feeblemindedness is of itself causing many institution officials to agree with the statement made in the report of the State Hospital Development Commission, that "the really reformable type is becoming in certain reformatories an almost unknown quantity and the number of defectives already so large that the question arises whether it would not be better to make one or two of these institutions actually 'defective delinquent' institutions and continue the others as reformatories with a population that is really reformable."

Table IX—Feebleminded Women Found in Certain Penal and Correctional Institutions in New York State

Institution	*Authority*	*Number of cases examined*	*Percentage feebleminded*
N. Y. State Reformatory (Bedford Hills)	Dr. Mabel R. Fernald	335	31.9
State Prison for Women (Auburn)	Dr. Mabel R. Fernald	76	25.0
N. Y. County Penitentiary	Dr. Mabel R. Fernald	105	26.6
N. Y. City Workhouse	Dr. Mabel R. Fernald	95	42.7
Inwood House (N. Y. City)	Dr. Mabel R. Fernald	69	15.1
Western House of Refuge for Women (Albion, N. Y.)	Dr. Jessie L. Herrick	185	33.5

We feel that the establishment of a clearing house and a reception prison at the New York State Reformatory for Women at Bedford Hills, through which would pass all sentenced women felons and those of lesser offenses selected by the courts of the state, is the most intelligent solution of the serious problem now presented by the delinquent women in New York State. The Laboratory of Social Hygiene might well be developed into an institution for this purpose. All of us are familiar with the serious consequences resulting from too long a delay in receiving into proper institutions feebleminded girls after they have developed marked delinquent traits, and especially is this true during the child-bearing age. Such a clearing house would function for those institutions handling the women prisoners of New York State in the same way that the clearing house at Sing Sing would function for men.

It is further suggested that in order to make effective the findings in this clearing house, a proper arrangement of the various other institutions handling women prisoners be made. In this

connection it is suggested that the State Prison for Women at Auburn be transferred to the State Farm for Women at Valatie, after being made more secure; that the Reformatory for Women at Bedford Hills be made the State Institution for Female Defective Delinquents; that the House of Refuge for Women at Albion be used only for those who are found capable of profiting by the training afforded and capable of being reconstructed to such a degree as would enable their restoration to the community.

CLEARING HOUSES FOR THE DEPARTMENT OF CORRECTION OF NEW YORK CITY

New York City, because of its extensive population, may be considered apart from the rest of the state, but all the facts deduced for the establishment of clearing houses at Sing Sing Prison and the Reformatory at Bedford Hills bear with equal force upon the needs of the Department of Correction of New York City.

For the year ending June 30, 1917, 71,528 prisoners were received in New York City institutions. A large army of physically and mentally handicapped individuals is being bandied about from institution to institution, locked up and turned out again and the process is repeated over and over. We are of the opinion that there should be established on Blackwell's Island two clearing houses, one for male prisoners and one for female prisoners, utilizing the old penitentiary for men and the workhouse for women, which plan is now under way. These institutions should be equipped with all the modern facilities suggested for the state clearing houses.

Through those two institutions should pass all the prisoners sentenced to institutions under the management of the New York City Department of Correction, and after proper study and treatment, and the character of the problem which each individual presents has been carefully outlined, they should be distributed to each of the city's correctional institutions in the light of the needs of each case.

It will be obvious that owing to the large number of mental defectives that will be found at these clearing houses, incapable of profiting by the ordinary methods provided in the existing machinery of the Department of Correction, two special institutions, one for male defective delinquents and one for female defective delinquents will be required.

PAROLE AND "AFTER-CARE"

The object after all in this more intelligent and more humane attitude towards the criminal is so to reconstruct his personality that he may be restored as promptly and as permanently as possible to his normal relation to society. In order to determine how far the prison administration has succeeded in this object, each individual prisoner when he becomes eligible for parole should be returned to the reception prison where he will be further observed, in order to determine how well this object has been accomplished. Much light on his fitness for parole and on the measures to be adopted in the after-care work given the case would be obtained through the knowledge gathered in the investigations made at the clearing house. Too much emphasis cannot be laid on this phase of the prisoner's treatment. Reformation of the offender is never fully accomplished within prison walls. At best such an environment is artificial.

The unusual success obtained in after-care work with the insane by certain psychopathic hospitals where, through the agency of a social service department, many formerly mentally ill patients have been satisfactorily adjusted to the conditions of normal living, may well serve as an example for after-care treatment of criminals, in connection with such clearing houses as are proposed. The period following the release of the prisoner is a critical one for him and may be fraught with most serious consequences to society.

PREVENTION THROUGH COURT CLINICS

Prevention is better than cure. Would it not be more sensible, more economical and more humane to prevent insanity, pauperism, prostitution, criminality and the like than to spend vast sums in undertaking to cure, or, when this was impossible, in providing ultimate custodial care?

It needs no argument to convince the average thoughtful person, that from the vast and grim procession of petty offenders passing through our lower courts, is recruited the greater portion of criminals eventually found in the prisons of this country. The large number of "repeaters" who have spent a greater portion of their lives in and out of prison, whose conduct has been in a measure due to serious abnormal conditions from which they suffered, such as mental disease or deterioration, feebleminded-ness, etc., could have been discovered long before they were sent to prison, at a time when deterioration in the mentally ill and

serious criminal tendencies in the mentally defective would have been more or less preventable. The state cannot afford to waste human material in such a manner or knowingly allow human beings to cause waste to other human beings in the community.

Studies have already been made calling attention to the frequency with which this same group of mentally disabled individuals is to be found in the courts. In a study made in 1917 by the Psychopathic Laboratory of the Police Department of New York City, of 502 selected cases, 58 per cent suffered from some nervous or mental abnormality. A study of female offenders by Dr. Clinton P. McCord at Albany showed 56 per cent exhibiting nervous or mental abnormalities. A study of 81 women examined in the night court of New York City by Dr. Mabel R. Fernald showed 25.4 per cent feebleminded. A study of 1,000 offenders by the Medical Service of the Municipal Court of Boston showed 23 per cent feebleminded, 10.4 per cent psychopathic, 3.17 per cent epileptic and 9 per cent mentally diseased and deteriorated. Of the 1,000 cases referred to, 456 or 45.6 per cent exhibited abnormal mental conditions. Every one of these 456 persons is a potential and probable candidate for ultimate custodial treatment.

We believe it would be practical economy to undertake proper adjustment of such individuals at a time when their condition may be recoverable, or serious delinquent tendencies preventable, rather than to wait until such deterioration has taken place or criminal habits have become so firmly fixed as to warrant custodial treatment.

How closely the problem of the mentally defective and diseased delinquent affects our courts, how seriously it hampers them in performing their protective function, is impossible, within the limited space available in this report, to discuss satisfactorily. However, a limited view of the situation as it is seen in the average lower courts may be obtained from the following table showing selected groups of problem cases studied by the Medical Service of the Municipal Court of Boston.

It may be seen from this table that among the problem cases passing through our lower courts, a strikingly large number of abnormal individuals is to be found—individuals unfitted to profit by measures intended for normal persons and as a consequence returning to the court over and over again, forming the very nucleus of recidivism.

Table X—Relationship of Mental Defect and Disease to Selected Types of Problem Cases in Court

Diagnosis	*100 Drug users*	*100 Immoral women*	*100 Shoplifters*	*100 Drunken women*	*100 Vagrants*
Normal	18	20	22	11	2
Dull Normal	20	32	12	21	8
Feebleminded	28	30	25	32	36
Epileptic	4	6	10	8	2
Alcoholic deterioration	..	2	..	7	12
Drug deterioration	14	2	..	..	4
Psychopaths	14	7	23	10	8
Psychosis	2	1	8	11	28
Total exhibiting abnormal mental conditions	62	48	66	68	90

There is no question more closely linked up with the fundamental duty of the criminal courts, the protection of society from antisocial acts, than the proper disposition of those who, through no fault of their own, are suffering from mental handicap, and who, because of their mental condition, are liable to become a burden and a menace to the community. This fact is being fully appreciated by judges throughout the country and in many places attempts are being made to secure proper medical assistance. In two cities, Boston and Chicago, special medical clinics have already been officially created within the municipal courts, contributory to a better understanding and a more intelligent treatment of offenders coming before these courts.

It is not to be expected that medical clinics in the courts can ever take the place of clearing houses in the prisons. Such opportunities for prolonged observation and investigation into the causative factors underlying careers, not to mention the advantages afforded from intensive vocational training and physical and mental rehabilitation of the prisoner, cannot be secured in the short time allowed for the study of a case in the lower courts. What these clinics can do, and most effectively do, is to act as a net or sieve for the court, to determine beforehand those who, because of constitutional defects and mental handicaps, are less likely to profit by the routine measures employed by the court in dealing with delinquents, and who, because of such pathological conditions, carry the potentialities for delinquent careers. As a result of the use of these clinics the feebleminded and mentally diseased and deteriorated persons will no longer be tried again and again on probation and after probation has failed, be sentenced for short periods of confinement in jails, lockups and houses of correction, losing thereby whatever opportunities there

might have been for restoring to health the mentally sick and preventing character deterioration and criminal tendencies in the mentally defective.

Such clinics should reduce the number of criminal insane. The early manifestations of their condition would be noted on the appearance of these individuals as petty offenders in the lower courts, and through the agency of the clinics, measures would be set in motion towards restoring them to normal health.

Through the establishment of such clinics, the feebleminded—the "mental children"—passing through adult courts, whose so-called crimes have been more the consequence of neglect and ignorance on the part of the community than of any innate wickedness on their part, will be dealt with squarely on the basis of their needs as well as their deeds.

But this is only a part of the helpful service furnished by medical clinics within the courts. The large percentage of criminals suffering from physical disabilities is attested by reports coming from penal institutions throughout the country. During the administration of Dr. Katherine B. Davis, arrangements were made to give all inmates of New York City correctional institutions the same physical examination as that required for admission to the United States Army. In the Reformatory for Male Misdemeanants of New York City, where the inmates average barely 20 years of age, only 8 per cent passed the required physical examination. In the penitentiary, where the average age is greater, only 5 per cent passed the required examination. In the workhouse, where those who are "down and out" are to be found in large numbers, only 1 per cent passed the required examination.

All studies that have been made of offenders passing through the lower courts show a startling number of individuals suffering from acute and chronic physical diseases, such as tuberculosis, Bright's disease, asthma, heart disease, syphilis and gonorrhea. The vital importance of the early recognition of these conditions cannot be overestimated. Their relationship to an individual's industrial efficiency and through this to his delinquency, may be seen from the following study made at the clinic of the Boston Municipal Court.*

* V. V. Anderson, M.D., and Christine M. Leonard, M.D. A Study of the Physical Condition of One Thousand Delinquents Seen in Court. *Boston Medical and Surgical Journal*, 178: 803–07, June 13, 1918.

A group of 1,000 delinquents was studied with the purpose in view of determining what part, if any, routine physical examinations might play in the disposition of a delinquent's case in court and later in the institutions of reconstructive measures while on probation. It was found that 85 per cent of those in good or fair physical condition had been and were still self-supporting, while only 18 per cent of those found to be in poor or bad physical condition had been and were still self-supporting.

That 96 per cent of those regularly employed were found in good or fair physical condition, while only 4 per cent were found to be in poor or bad physical condition.

That 86.3 per cent of those who were rated as "never worked" were found to be in poor or bad physical condition. The chances of being self-supporting were more than four to one in favor of the individual in good physical condition.

Further, 47 per cent of these individuals, practically every other person, was suffering from syphilis or gonorrhea. Only positive laboratory findings were included.

Certainly something more than intelligent advice, short terms of confinement in prison, general supervision in the community and securing employment, is needed to solve the problem presented by the delinquent whose physical endurance is rapidly diminishing under a progressive Bright's disease, or the delinquent who is scattering syphilis and gonorrhea broadcast into the community. These may be conditions of more vital importance to his future welfare and to that of the community in which he lives than any other consideration.

The help that medical clinics will be to the court in determining the presence of these conditions and securing the proper protection to the community and treatment of the individual is obvious.

It is not necessary in such a program to emphasize the part played in the prevention of delinquency by the juvenile court. Dr. William Healy, Director of the Judge Baker Foundation of Boston, has well said:

"The determinants of delinquent careers are the conditions of youth. Observers in many quarters are united in stating that almost all recidivists, confirmed criminals, show plainly their tendencies at least by late childhood. The factors then that turn the individual toward misbehavior are those already present in childhood."

This very fact and the presence of feeblemindedness and other

nervous and mental abnormalities among delinquent children, and the splendid work done in connection with juvenile courts by Dr. Healy in Boston, Dr. Helen Montague in New York City, and others, have convinced those who have given serious consideration to this phase of the subject, that the financial saving in the prevention of delinquent careers, resulting from such studies and reconstructive work as have been done through already established clinics, more than justifies the financial outlay for their maintenance, to say nothing of the humanitarian aspect of the work.

So important are those beginnings of delinquent careers as found in childhood in their relation to the whole question of criminality, that a thoroughgoing study of each delinquent child brought into court is an ideal which the state can most profitably set itself to attain.

The establishment throughout the state of mental clinics to accomplish such aims will prove to be an investment paying in dollars and cents saved from the expense of courts, prisons, reformatories and almhouses; an investment not only in the prevention of crime and poverty, but in the joy and happiness coming from well adjusted human lives. Clinics functioning not only for the courts, but for the schools and the entire community, will be a center from which radiate influences tending to prevent many of the social, mental and moral wrecks of the coming generations.

Undoubtedly from existing knowledge as to the development of personality traits and mental characteristics it will be possible, through the study of the peculiar, retarded, abnormal and subnormal children in the schools and the community, to set in motion measures for the development of desirable character traits and for the inhibition of undesirable ones; and to select very early in their careers those children in need of very specialized treatment.

It is evident in the larger cities, particularly in New York City, owing to the great number of delinquents passing through not only the adult courts but the juvenile courts, that special clinics attached to those courts will be necessary.

We note with approval that a comprehensive plan for mental clinics is being worked up into a state-wide program by the New York State Commission for the Feebleminded. Under the provisions of the Lockwood Law, the abnormal and backward child in school will be carefully studied and suitable measures

applied for his readjustment before he has become a delinquent child or an industrial failure.

The various clinics throughout the state should be supervised and their activities directed, as the State Commission for the Feebleminded plans, by a state board to govern all such clinics. An important step forward in the realization of this whole program for the prevention of delinquency would be taken by the establishment of a psychopathic hospital in New York City as has been proposed by the State Hospital Development Commission. Such an institution would serve to prevent many individuals from becoming permanently disabled by mental disease, and throughout the community serve as a stimulus for better mental hygiene. It also would be of practical service in the prevention of delinquency, in that many individuals who would otherwise become serious problems for the courts and penal institutions of the state, would through the activities of such an institution be enabled to adjust themselves to the conditions of normal living.

In conclusion, the Committee desires to express its appreciation to Dr. Anderson for his very valuable assistance in the investigation and in the preparation of this report, and to The National Committee for Mental Hygiene for its cooperation and advice.

RECOMMENDATIONS

1. That all males convicted of felony and not released under suspension of imposition or execution of sentence pass through the proposed clearing house at Sing Sing Prison, and thence be distributed to each of the state prisons and the New York State Reformatory at Elmira in the light of the needs of each case.

2. That all sentenced female felons and those convicted of offenses of a lesser degree than felony selected by the court, pass through a clearing house to be established by the state at the New York State Reformatory for Women at Bedford Hills, and from this clearing house, after a period of study and reconstruction, be distributed to other state institutions for women in the light of the needs of each case.

3. The prompt establishment of the proposed clearing houses on Blackwell's Island to function for the Department of Correction of New York City in the same way as the Sing Sing and Bedford Hills clearing houses function for the state institutions, converting the penitentiary into a clearing house for men and the workhouse into a clearing house for women.

4. The establishment of a state institution for the care and treatment of male defective delinquents, providing for their commitment, release and transfer. The Eastern New York Reformatory at Napanoch is suggested.

5. The establishment of a state institution for the care and treatment of female defective delinquents, providing for their commitment, release and transfer. The New York State Reformatory for Women at Bedford Hills is suggested.

6. The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of male defective delinquents.

7. The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of female defective delinquents.

8. That all children brought before the court, charged with delinquency or improper guardianship, be examined mentally, the examinations to be made either in a clinic attached to the court, or in a central clinic to be provided, and those found feebleminded to be committed to proper institutions if in need of institutional care.

9. That all adults convicted of offenses less than felony and all adults convicted of felony and released under suspension of imposition or execution of sentence, be examined mentally at the discretion of the judge at a clinic attached to the court or at a central clinic.

10. The establishment of mental clinics throughout the state as planned by the State Commission for the Feebleminded, and the establishment of a psychopathic hospital in New York City as proposed by the State Hospital Development Commission.

11. The creation of a state board to supervise and direct the activities of these mental clinics, thereby securing proper standardization in the way of methods used and results obtained.

12. That the Legislature be requested to enact such legislation as will put these recommendations into effect.

THE RESPONSIBILITIES OF THE UNIVERSITIES IN PROMOTING MENTAL HYGIENE

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MENTAL disorders are among the most obscure diseases to which man is liable, and many problems as to their cause and nature still await solution. An important fact to realize, however, is that we have at present a great deal more knowledge about these disorders than is actually being utilized. A great deal can be done for the general hygiene of the community by merely making efficient the knowledge which we actually possess.

Some of this knowledge is very definite and simple, and furnishes very positive directions as to conduct. The knowledge that a fatal and very prevalent form of brain disease (paresis) is due to syphilis should be disseminated as widely as the knowledge of the causation of typhoid by contaminated water.

The physician who has to deal with cases of mental disorder frequently finds that the symptoms are not due to any form of poisoning or to any visible damage to the structure of the brain, but that they can only be understood as a poor and unhealthy attempt of the individual to adjust himself to the actual difficulties in his life.

The problems in face of which the patient has broken down may seem somewhat commonplace and insufficient to account for the failure of adjustment, but the latter becomes intelligible when we analyze the inner life of the individual and study those forces in the patient's nature which are most potent with regard to the determination of conduct. This study reveals to the physician how much the conduct of each individual is determined by factors of which the latter has very little inkling, accustomed as he is to look upon his life as wholly composed of conscious, purposeful activity, determined by clear, logical thought. Beneath this level of purposeful activity and clear thought, factors of the greatest dynamic importance are at work, factors which are largely responsible for the symptoms of mental disorder.

Frequently the thorough study of the patient's sickness shows that the balance of forces, which results in the mental disorder, has been largely determined by the whole development of the

patient, by the experiences and habits of childhood, by the degree of assimilation of the developing instincts at puberty, by the general methods which the individual has adopted to get satisfaction out of life in the face of actual, external circumstances and his own inner difficulties. In the adult many of these difficulties of the child and adolescent still remain undigested, they appear to be forgotten because they are barred from the clear consciousness of the individual.

In the large group of cases to which the above principles apply the physician may not have learned to modify the symptoms of the developed disorder to any appreciable extent—perhaps this may not be possible at a certain stage; but in tracing the steps in the development of unhealthy habits of thought and activity he may see how, at an early period, the possibility of modification was still open. The physician, as he looks over the history of the patient, is struck by the fact that during the developing period when help might have been given no person seemed responsible for giving this help. It seemed to be the function neither of the parent nor the teacher, the family physician nor the religious adviser, to direct or correct important tendencies in the adjustment of the individual to vital demands of his life. Even when danger signals appeared in the shape of moods, wayward reactions, daydreaming, odd attachments, unwise enthusiasms, seclusiveness, unusual interest in religion or abstract questions, no serious attempt was made by any one to know what factors beneath the surface led to the observed peculiarity.

It is obvious that an accurate knowledge of the above facts cannot be directly disseminated in the same way as facts relating to syphilis, alcholism, tuberculosis. This knowledge should, however, be at the disposal of all who are responsible for directing the lines of social and educational progress. It should be part of the equipment of those who have most to do with molding the development of the rising generation. The detailed knowledge of the forces which actually are at the root of human conduct must filter down into the community from the centers which inspire alike the teacher and physician, the religious instructor and those who mold public opinion through the press; these centers are, of course, the universities.

How far do the universities fulfil their responsibilities with regard to the mental hygiene of the community? It is doubtful whether they have attained a clear recognition of the fact that a

man's mind may be richly supplied with a great variety of special information, that he may have attained a high intellectual level, and yet the man's life may be rendered inefficient because it rests upon insecure foundations. An education may enable a man to solve abstruse intellectual problems, and yet leave him so hopelessly unable to cope with a bereavement, an unsuccessful love affair, difficult marriage relations, or even simple instinctive impulses that he may lose control of the direction of his life and for a period be dominated by factors which have been almost entirely repressed in his conscious life; the disorder may be so marked as to be included under the wide term "insanity."

To rear a superb intellectual structure on such a foundation is surely not an ideal education; it is like building a house on the sand, or, to speak more hygienically, it is like building a superb mansion without paying any attention to the plumbing.

It is striking to see a man of brilliant intellect, who discusses fearlessly the riddle of the universe, unable to face the fact that in his own human nature elements are still active that are derived from the brute, the savage, and the child; even the humility of the theologian may not enable him to see himself in his actual biological composition.

If the university allows the student to face the problems of his life after an education which gives him no thorough insight into his own nature and its fundamental difficulties, does it at least give the teachers sufficient insight into the subtle structure of the child's mind to enable them to realize the importance of their problems?

It is important that the teacher should free himself from the myth of the golden age of childhood and should realize what the boy thinks and feels, what he longs for, how his daydreams go, what his curiosity is about, what vague feelings and actions are prompted by the first germs of the developing sexual life, what are the conflicts in the mind of the boy, and how he faces them or avoids them.

The teacher should have at his disposal the facts relating to the emotional life of the child. He should learn that the diffuse groping of the infant and child for organic satisfaction is pregnant with forces which are going to make or mar the life of the individual, and give him his individual stamp and determine his social efficiency. In this groping for satisfaction we can trace the origin not only of the instinctive life of the individual with its

nutritive and reproductive elements, but also the roots of those higher activities which give human life its special value. In tracing these higher functions to their roots we do not cease to appreciate the beauty of the flower; we are willing, however, to be practical gardeners. We wish to care for the roots, not because grubbing in the soil has any particular charm, but in order that the plant may grow up hardy and beautiful. When we study the child we see how the groping for organic satisfaction inherent in all living matter brings the child into closest contact with the mother. As the child develops, this attachment to the mother may express itself indirectly in a certain moodiness or even direct antagonism to the father. The affection toward the boy's mother is only one element in the boy's nature but it is strong enough to assert itself in numerous obscure ways, and in the aduit man it still exercises its influence and modifies the sexual life at a deep level in ways which escape his own notice. One may simply refer to the well known fact that one man may remain single through devotion to his mother, while another man may marry a woman who reminds him of his mother. In the tragedy of Sophocles, in which Œdipus marries his mother Jocaste, the tremendous conflict between the childhood attachment and the adult repression furnishes the universal human motive of the play. It must not be thought that these remarks apply only to special or somewhat perverted individuals; the same elements, in various degrees, are present in the life of every one of us and manifest themselves in dreams, in casual reactions, in likes and dislikes, and in purposeful decisions, the meaning of which sometimes escapes us. The knowledge of these facts is of the greatest use in allowing us to understand the peculiar moods of the child, the occurrence of unexplained jealousies and antagonisms and wayward reactions.

Out of the vague groping for organic satisfaction of the infant there develops at an early age the first indications of what is later to be the sexual instinct; during the early period of development the sexual is as yet somewhat diffuse and poorly localized and there is a tendency of the child to find satisfaction in many directions which, if persisted in, would mean the development of a definite perversion. In every one probably, as William James remarks in his *Textbook of Psychology*, there are the germs of such possibilities. The growing individual is like a plant with numerous shoots, each one of which might become the main stem.

A healthy withdrawal of energy from the side shoots strengthens the growth of the main stem and in that direction normal development lies. The teacher should not ignore that these side shoots have been present and that, although they may not be distinctly recognized by the growing individual, they may still have latent life and express themselves in a direct or indirect way. Over-enthusiastic attachment to a comrade or to a teacher may derive its strength from childhood tendencies which in less fortunate individuals actually develop into adult perversions.

As the boy develops, the groping for somatic satisfaction becomes more clearly specialized, the range of his interests becomes wider and the thirst for knowledge leads to eager questioning. The universality of the interest of the child in questions like childbirth shows its great importance to the child. In this curiosity we see how the desire for knowledge, which we are accustomed to look upon as a somewhat abstract intellectual tendency, has its roots deep down where the roots of the sex instinct also lie.

It is wise for the teacher to study this problem of the curiosity of the child, to convince himself that it does exist, and come to some conclusion as to what is to be done with it. The teacher can hardly be satisfied with the conventional method of telling the child a silly lie, which seldom deceives the child. The teacher can hardly approve of casting an air of mystery over anything which is sufficiently important to have caused a question in the child's mind. If we must not lie and if we should not be mysterious, the teacher has to consider how he can answer the questions of the child in a way which will help the child's development. All knowledge is gained by enlarging the sphere of existing associations; the teacher may well consider what associations the child has to which an honest answer to his question may be added. The teacher may recognize that without the knowledge of a few simple, biological facts it will be difficult to give the child any useful information and it may well be a point for discussion how far a simple knowledge of biology should form an essential part of the instruction of every child. This may be a great benefit to the adolescent when personal difficulties are apt to become intense, for then the information which the young man requires will merely mean the further development of what he already has, and will not consist in a series of propositions which he finds impossible to bring into any coherent relation to the

store of Latin, Greek history, English roots, or conic sections, which have represented to him the products of education. In laying due weight on biology the teacher is preparing the boy to understand in its complete setting those higher biological adjustments which are the special province of psychology.

As the boy becomes older, out of the vague groping for somatic satisfaction there develops the haunting solicitation of sexual desire. The influence of cultural environment has already impressed the boy so that these personal difficulties cannot be frankly discussed and digested. Innocent questions and general curiosity as to childbirth and sexual matters in general have elicited either a lie or surprised horror, and the boy has learned that, for some reason or other, the subject is taboo. The conflict between the various forces is necessarily severe and in the individual case is sometimes disastrous. What does most harm to the individual is not the occasional self-abuse during the developing period, but the fact that the habit should not be clearly understood and the fact that the boy endeavors in an evasive and dishonest way to eliminate its painful memory instead of understanding the factors which led to it and dealing with the difficulty in an honest, healthy way. As it causes the boy distress and a feeling of conflict he atones for it in other ways, and sometimes we see a precocious interest in religion which has no more sound basis than the fear of being honest with himself.

This becomes still more marked in cases of mental disorder, as was the case of a patient addicted to self-abuse who referred to the toilet as the "sanctuary."

Sometimes efforts are made to be frank with boys, but unfortunate methods are adopted; it seems very unwise to try to help a boy in this direction by telling him that self-abuse leads to insanity, or to use similar threats. It would be better, surely, to let the boy know that the special instinct associated with special organs is going to be one of the most important elements in his life, and is one of his highest responsibilities. He should be told that to use his organs merely for a transitory pleasure is to use them for a wrong purpose, and that it will make it probably more difficult for him to live up to his fuller responsibilities when the time comes. He should be encouraged to be careful of himself in order that, when circumstances entitle him to enter into the reproductive life, he shall do so keenly conscious of what such relations mean.

The various minor disorders which crop out when the boy is having difficulty with the sexual instinct are well worth the attention of the teacher. Parents probably have not received the necessary training with regard to this matter. The family physician probably does not have the boy under observation. The teacher has the boy under comparatively long periods of observation and should be taught to recognize the various indications that the boy is having difficulty with his life.

The teacher may perhaps be delighted with the intense application to study shown by a pupil who is by this very method endeavoring to make up for what he feels are shortcomings in a field which he dare not mention.

Quite apart, however, from the occurrence of any special disorder at this period, the mere habit of repressing difficulties without understanding them is a bad preparation for the tasks of the adult life, where the individual may have to meet more serious difficulties. The habit of repression which may lead to disaster at 30 or 40 or 50 is largely due to the education before the age of puberty.

When a young man passes into university life, is the atmosphere of the university sufficiently tonic? Does the university keep sufficiently in mind the necessity of seeing that the foundations on which the intellectual superstructure is built are solidly constructed? The universities not only have the responsibility for giving those within their walls an opportunity of organizing their life in a hygienic way, they have a glorious opportunity presented to them: the undergraduate is at an age when ferments are working in his system, when the character is still plastic, when the repressing forces of the modern cultural environment have not yet become too despotic. He has the desire and also the courage to know, and in his youthful enthusiasm to achieve great things, he can be persuaded to take difficult steps in the direction of self-knowledge. To a certain extent the undergraduate makes progress in this direction by means of frank social intercourse with his fellows, which is undoubtedly one of the soundest educational forces of the university. He, however, receives this in a form which is much too casual, and the benefit from the smoking-room may be made much more systematic and thoroughgoing in the clearer atmosphere of the lecture room, the laboratory, and the lecturer's consulting room. On the department of psychology would fall the primary respon-

sibility for this branch of education of the undergraduate, and the psychology would need to deal with the higher types of human adjustment (feeling, will, thought, conduct) in the full light of our knowledge of the biological roots of these activities.

The problems and methods of the psychologist might have to be enlarged and the experiments of the psychological laboratory would have to be supplemented by the study of other fundamental experiments, which are seen in the home and the hospital.

The city is a great experimental laboratory and the subjects of experiment are not merely logical, purposeful men who work and become fatigued; they are actual living, illogical, lustful men who are striving to adjust themselves to their environment in such a manner that life brings them satisfaction. From the study of the results of these experiments—in other words, from the study of his patients—the physician gains a deeper insight into the structure of the adult and the relation of adult conduct to early development than can be gained in any other way.

The department of psychology, therefore, must include the study of psychopathology, and of a psychopathology which takes into consideration the most vital factors in human life. In such a department the students would have not only an opportunity of receiving systematic instruction, they would be able to work at the problems of their own individual lives and to receive useful advice from those in charge of the department. This advice might be of the greatest use with regard to the coordination of their various studies while at the university, and might guide them in the choice of a curriculum really suited to their needs and aptitudes. The work done by students in this department might be of far-reaching importance; the systematic analysis of their own difficulties and adjustments and of the development of the same by a group of students would be a contribution to psychology of a most valuable nature.

Teachers who had honestly taken advantage of such a course of study would be much better prepared to discuss seriously the important problems of general education. Having come to an honest understanding of themselves, they would be able to do much toward creating a healthy atmosphere for the discussion of various topics of fundamental importance, which at present are too frequently ignored.

If a great responsibility rests on the university for the satisfactory equipment of teachers, an equally clear responsibility

exists with regard to the adequate training of physicians. The teacher cannot be expected to have the same detailed knowledge of unhealthy reactions possessed by the physician nor is he especially trained to deal with the same. The most that the teacher can frequently do is to call the attention of the parents to certain danger signals and to recommend that a medical opinion be sought.

In many cases of mental disorder, both in the young and adult, the family physician has had the opportunity of seeing the symptoms at the very earliest stage. The physician as a rule has had the education of his fellows. He has seldom received any special training in psychology, his training in the study of mental disorders has, as a rule, been of the most superficial description and has frequently been confined to a few systematic lectures on certain kinds of disorder which he is expected to name and recognize, and to a few demonstrations of patients who have possibly interested him as a medical student more from a dramatic than a medical point of view.

It is no wonder that the family physician with this equipment, with no special insight into these fundamental difficulties of adjustment to life which express themselves in odd manifestations, should be quite at a loss when confronted with rather vague and evasive symptoms, which are frequently the precursors of more serious trouble. The individual may have peculiar headaches or a change of mood or may feel suspicious or unusually irritable or may have unexplainable physical symptoms or feelings of anxiety or fear. He may have an obsession to do things an unreasonable number of times, or there may be a sudden lack of interest in life or an ungrounded jealousy. The possibility of helping the patient is very much greater if the patient is seen at an early stage of the disorder and if, at this early stage, the whole situation is thoroughly gone into. It does not do to meet very definite symptoms like the above with general prescriptions. A course of tonic medicine or a sea voyage will not charm away the disorder which is due to certain difficulties, which the patient takes with him on his sea voyage, and which cannot be reached by any drug poured into his stomach.

It is obvious that the university must make provision in its medical course for adequate teaching of the whole subject of mental disorders. It should be compulsory for each medical student to have a separate course in the department of psychology.

He should have an opportunity before he leaves the medical college to examine personally and study actual cases of mental disorder. In order that such opportunities may be available, wards for patients with mental disorders should be at the disposal of the teaching staff of the university. The medical college should have either a psychopathic clinic at its disposal or psychopathic wards in the general hospital where its teaching is done. A medical man with a satisfactory grasp of the principles of psychopathology would be in a position to contribute a great deal to the mental hygiene of the community in which he lives.

It does not seem necessary to take up in detail the rôle played by the religious adviser, and by those who help to mold public opinion through the newspaper and the periodical press; they, too, may be considered as belonging to the teaching class and those of them who should have passed through a university, which fulfilled its responsibilities toward the mental hygiene of the community, would leave it with a self-knowledge which would make them very potent agents for good in creating a healthy social atmosphere.

To state briefly the points which this paper aims at emphasizing:

(1) The lack of guidance in childhood, adolescence, and early adult life is one of the causes of the development in the adult of a great variety of nervous and mental disorders, varying from frequent headaches, peculiar mannerisms, anomalies of mood, odd interests and enthusiasms, to disorders of conduct sufficiently pronounced to be called insanity.

(2) Those primarily responsible for giving the necessary guidance are the parents and teachers, the family physician and the religious adviser.

(3) The parents cannot easily be reached directly.

(4) The teachers can only take up the problem efficiently when their own education deals frankly with many problems of life which are too frequently ignored although they are of fundamental importance.

A course of psychology for teachers is quite inadequate unless it deals thoroughly with the basal forces of human nature, with the instinctive roots of conduct, and with the various surface phenomena which crop out above the surface when the instinctive life of the individual is being badly managed.

(5) The student at the university should not only have the opportunity of developing his intellectual efficiency and of casu-

ally deriving personal benefit from frank intercourse with his fellows; he should in every case have a course of instruction dealing with the fundamental problems of human life, and in this department should find a suitable opportunity for facing his own personal needs and difficulties, and placing his intellectual development on the sound basis of a healthy and clearly understood instinctive life.

(6) No medical college is fulfilling its responsibility toward the community unless it provides its students with a satisfactory opportunity of studying mental disorders in their earliest phases, and trains physicians to recognize early and to regard seriously the symptoms of disordered balance in the child and in the adult.

Brevity is the soul of wit, but also the source of misunderstanding; this brief paper may bring little conviction and cause some offense. My plea has been that the universities should aim at making men wiser, and to indicate the spirit of this plea let me quote the following passage from an author of marvelous intuition, a master of simple and accurate expression.

"As we become wiser we escape some of our instinctive destinies. There is in us all sufficient desire for wisdom to transform into consciousness most of the hazards of life. And all that has thus been transformed can belong no more to the hostile powers. A sorrow your soul has changed into sweetness, to indulgence, or patient smiles, is a sorrow that shall never return without spiritual ornament; and a fault or defect you have looked in the face can harm you no more, nor even be harmful to others . . . whoever is able to curb the blind force of instinct within him, is able to curb the force of external destiny also. He seems to create some kind of sanctuary, whose inviolability will be in the degree of his wisdom; and the consciousness he has acquired becomes the center of a circle of light, within which the passer-by is secure from the caprice of fate. Had Jesus Christ or Socrates dwelt in Agamemnon's palace among the Atrides, then had there been no Oresteia; nor would Œdipus ever have dreamed of destroying his sight if they had been tranquilly seated on the threshold of Jocaste's abode."

THE PSYCHIATRIC THREAD RUNNING THROUGH ALL SOCIAL CASE-WORK*

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IT is clear at a glance that the title of this paper is inaccurate, for when you come to look for the psychiatric thread running through social case-work you see at once that this *thread* constitutes the entire warp of the *fabric* of case-work. Inasmuch as the adaptation of an individual to his environment, in the last analysis, depends upon mental make-up, the study of the mental life is fundamental to any activity having for its object the better adjustment of the individual. The special function of social case-work is the adjustment of individuals with social difficulties. It is the art of bringing an individual who is in a condition of social disorder into the best possible relation with all parts of his environment. It is the special skill of the social case-worker to study the complex of relationships that constitute the life of an individual and to construct as sound a life as possible out of the elements found both in the individual and in his environment. Our relations to our environment are caused by mental, physical, and economic factors existing in our own experience and in the experience of other persons. It is no matter which of these three classes of factors is considered of *primary* importance since they are all of *fundamental* importance in dealing with a case of social disorder. It would be hard to say which leg of a three-legged stool is the most necessary to our comfort. From the standpoint of treatment there is practical value in knowing which field is the source of greatest difficulty; but in the analysis of a case of social disorder, consideration of no one of the three classes of factors can be safely omitted. Furthermore in treatment, with few exceptions, some consideration of all three will be required even where one predominates.

Social workers in attempting the social adjustment of an individual draw upon the knowledge of all sciences for their own use and depend upon the skill of all other practitioners in behalf of

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their clients. Leaving out of this discussion the economic and physical factors of social maladjustment, let us discuss the means by which we deal with mental factors. Almost everybody acquires by experience of life a rough and ready knowledge of psychology, and most social workers study psychology as part of their general education. When in the course of our work we have a patient who is mentally sick, we call upon a psychiatrist. The question naturally arises whether it is not the psychological thread that forms the warp of social case-work with the psychiatric thread making an occasional morbid pattern. That is, can psychiatry do anything more for social case-work than treat mentally sick persons? Is it not knowledge of psychology rather than psychiatry that we need, except in the rare cases of mental disease? The analogy of physiology and medicine will perhaps help to clear up this question. It is generally agreed that the social worker needs some familiarity with the essentials of medicine, and that as a basis for such knowledge some acquaintance with physiology is necessary. If it should be granted that the social worker needs to know something of psychiatry, a previous knowledge of psychology would have to be assumed. Roughly speaking psychology tells us what the mental processes should be, psychiatry shows what these processes actually are in a given case. Psychology establishes the average or norm for our guidance, while psychiatry points out all possible variations from the normal. If all men were of the same order, psychology would be sufficient for our needs, but since human nature is subject to innumerable variations, it is necessary to understand the peculiar character of the individual before applying the principles of psychology.

In social case-work we are dealing with individuals in the most intensive manner possible; therefore, we are immediately concerned with the particular variations of each individual. And a very large proportion of persons with whom social workers deal vary sufficiently from the average to present a psychiatric problem, that is, to call for the use of knowledge that is to be had from psychiatry and not from psychology. This fact, that a majority of social cases are psychiatric problems, is probably not yet generally recognized. It is common knowledge among us that medical problems are prominent in case-work, and few would deny that the case-worker needs to know some medicine in addition to physiology. But the recognition of the extent to which mental disorder enters into social problems has only begun to

dawn upon us. Knowledge of psychology has for some years been held essential, but for the most part social workers look upon psychiatry as a subject that it is hardly safe to touch, or at any rate only after laying a foundation of "normal psychology" as they say, upon which to lay firm hold in order not to be swept away into the unpleasant morbid realms to which they imagine psychiatry will lead them. The old unhappy prejudice against mental disease which still holds sway over this generation is, of course, responsible for this prevalent misconception. But social work must be free from prejudice, if it is to take its place among professional and scientific endeavors. It is a mistake to think that familiarity with the abnormal breeds contempt for what is sound and wholesome. We turn from sickness with an increased appreciation of health. I remember how good the sunlight looked when I came out of a coal mine, yet I had felt very much at home down in the mine. Knowledge of mental disease gives added value to mental hygiene. I am sometimes asked if familiarity with psychopathic cases does not make everybody seem a little psychopathic. On the contrary, the psychopathic seem to the psychiatric social worker more like everybody else, but persons of sound personality seem more admirable than ever.

When social workers talk of working only with "normal persons," as I often hear them say, it is not clear what they mean. Several managers of large firms have told me that they employed only "normal people." We rarely use the term "physically normal," for almost no one is completely healthy or well all of the time. It is just as true that no one has a mind in perfect condition or maintains an even state of mental health. The term "normal" applied to the mentality of an individual has no exact meaning; but it is a very serviceable word if taken to mean that a person's mental condition is such that barring accidents he is likely to get on in the world without difficulties. The normal person is one who is able to adapt himself to his environment. In this sense, a person who is normal may have slight mental disorders, just as a well person may have a headache, a toothache, or a cold. We are an assembly of normal persons, but probably no one of us could claim never to have had any sort of mental or nervous trouble. A psychiatrist once assured me that if anybody believed himself to be of perfect mind, he would be ashamed to own it, knowing that he would be regarded as uninteresting. For some reason we are not entirely sympathetic toward the perfect in nature.

The actual number of acute psychiatric problems to be found among the cases of all social agencies is far larger, I believe, than we are accustomed to think. Fifty per cent of the cases cited by Miss Richmond in *Social Diagnosis* present clearly psychiatric problems, and another 15 per cent strongly suggest a psychopathic condition. In many of the 35 per cent where mental disorder is not indicated, the brief mention of the case does not show its absence conclusively. So that of these cases taken from various agencies and cited in illustration of a variety of points, over one half at least probably called for social psychiatric treatment.

A recent review of 50 consecutive applications to the Boston Associated Charities showed 36 individuals in these 50 families who were probably psychopathic, 24 of these were clearly so, and 12 were strongly indicated to be so. In 14 cases the personality of one or more members of the family was not indicated. It is not safe to assume that mental difficulties do not exist when not recorded in social records; so that 36 persons in 50 cases is probably below the true figure.

Fifty consecutive admissions to the placing-out department of the Boston Children's Aid Society showed 45 persons with mental disorder indicated—10 children, 22 parents, and 6 near relatives clearly psychopathic, and 7 parents presumably so. Nineteen of the 50 were cases of infants, so that the figure 45 psychopathic persons in 50 cases may be below the fact. Of 297 children in the care of the Society on May 1, 23 were known to be psychopathic and 29 were under observation, making 52 children requiring social psychiatric treatment—17½ per cent.

Another children's agency in Boston, which gives routine tests, the New England Home for Little Wanderers, found in 100 consecutive admissions, 50 children of normal intelligence and 50 who required further observation or special care, 4 of whom were feebleminded. In two other studies made by this agency of 201 children and 174 children, the percentage of psychiatric problems was 45.3 per cent in the first group and 45.9 per cent in the second group.

The Church Home Society in Boston, a placing-out agency for children, has adopted the practice of a routine psychiatric examination for all children admitted to its care. A psychiatrist is attached to the staff of the Society, who not only examines but observes and treats the children in its care. The psychiatrist's report on 100 children shows 44 requiring psychiatric treatment.

The routine mental examination practiced by this agency is regarded by some social workers as an unnecessary luxury and in the nature of a fad; but since nearly half of its children are found to be psychiatric problems, the practice would seem to justify itself. The Secretary of the Society, Miss Hewins, told me that the agency profited not only by the advice given in cases of mental disorder but also from several by-products of the psychiatric clinic, (1) detection of superior ability in children, to whom exceptional educational opportunities were given, (2) advice to visitors in regard to training normal children, (3) improvement of records due to the necessity for more exact information required for psychiatric study.

Several years ago in a paper entitled *Routine Mental Examination as the Proper Basis of Practical Measures in Social Service: A First Study Made from 30,000 Cases Cared for by 27 Organizations in Boston and Surrounding Districts*, Miss Helen Wright, assistant in the Social Service Department of the Boston Psychopathic Hospital, compared the reluctance of social agencies to adopt routine mental examinations to the early opposition to the idea of investigation. She said, "When pioneer workers in organized charity and reform movements urged *investigation* as the only scientific basis for rendering charitable assistance of any kind, at first an investigation was made very guardedly and very superficially by the societies then in a position to make one. As time went on, certain cases were inquired into carefully as a matter of principle, but others were put aside as 'too sensitive to be investigated,' 'evidently all right.'" No efficient agency today would dispense with the routine inquiry into the social condition of a client, but few agencies are yet persuaded of the necessity for routine inquiry into the mental condition, which might seem to be even more important as a basis for social treatment. Miss Wright found 3 per cent of mental cases in family agencies, 4.5 per cent in children's agencies, 7.9 per cent in temporary homes for women. Two agencies for unmarried mothers that made a practice of routine mental examinations showed 17.9 per cent and 23 per cent of mental cases respectively. The other agencies detected mental disorder only when some acute condition made an examination necessary, and without question were dealing with a higher percentage of mental cases than they were aware.

A study of 2,600 admissions at the Boston Psychopathic Hospital showed that 30 per cent of the cases were known to social

agencies before admission, over half of this number to more than one agency, 15 per cent of them to five or more agencies. In the social work for these 800 odd cases 139 agencies were involved before they came to the Psychopathic Hospital. It is not known of course at what point the agencies recognized mental disorder in these cases; but the figures are an indication of the amount of social work that may be required by frankly psychopathic patients.

The greater part of the case-work of the social service of the Psychopathic Hospital is essentially the same as the work of other social agencies. For example, in 100 current intensive cases there are 65 cases presenting family problems such as might have fallen to the lot of a charity organization society. There is a misconception, which is sometimes heard, that the psychiatric social worker has a different function from other social workers. She has exactly the same function of social case-work, including, as the figures above quoted indicate, family case-work. The characteristics which differentiate the psychiatric social worker are (1) knowledge of nervous and mental disorders, (2) experience with psychiatric cases, and (3) a point of view which seeks for the causes of conduct in mental factors.

Most social agencies will tell you that their files are full of cases that would have received different treatment if the psychiatric problem had been discovered earlier. The loss to the client as well as the waste of effort on the part of the agency caused by misdirected treatment in such cases is obvious.

Social case-work habitually relies upon psychiatry for advice concerning the care of persons with mental disorder. This advice is indispensable and very important. But perhaps even more important is the help that psychiatry can give the social worker in understanding human nature and in dealing with the many varieties of human personality that come before the social agencies. Personalities that would be considered normal frequently present many irregularities and contradictions. When we have come to understand these peculiarities as they appear in exaggerated form in psychopathic cases, we can more readily understand them in the average person. Besides frankly psychopathic cases, the social worker deals with persons whose apparently slight peculiarities may be the result of some marked psychopathic trait, with other persons who have very mild degrees of psychopathy, and with still other persons who are approximately normal in all mental characteristics. Whether we are dealing with pronounced

psychopathic traits, or minor peculiarities, or normal mentality, the psychiatric point of view is invaluable in social case-work. By the psychiatric point of view I mean the habitual recognition of mental causes of conduct together with some knowledge of the nature of the mental processes that may cause conduct disorder.

The social worker who has completely acquired this attitude of mind will, to begin with, secure in the original investigation of a case information concerning the mental life and conduct of the individual which will give her a better knowledge of his personality than most social records now reveal. Through history and subsequent observation along the same lines, cases of marked mental disorder will be detected as early as possible. As a rule we wait until some acute mental trouble has developed before calling upon a psychiatrist or giving special consideration to the mental condition in our cases. Frequently cases come to the Psychopathic Hospital, through some accident or other, that have been dealt with by social workers for years without recognition of the mental disorder. A young woman, the mother of an illegitimate child had been a "difficult case" in various agencies for seven years, and 24 different agencies had been interested in her family. During the six months that the social service had supervision over her, she got on fairly well within the limitations of her psychopathic make-up.

Sometimes the social workers from other agencies find it hard to believe that certain patients at the Psychopathic Hospital are cases of mental disorder. At a special clinic for medical social workers a woman was presented who had been brought to us after an attempt at suicide. She had been at odds with family, friends, church, employment, and with herself, and had been drinking and fabricating. She told the story of her difficulties and how she had regained her position in life with the help of the social service in a straightforward, rather attractive way. Afterwards a prominent social worker told me that she thought we should have presented a different sort of case, for, she said, "that woman is just like all the people we are dealing with." Yet this patient was distinctly a psychopathic person and required a very definite sort of psychiatric treatment.

Recently at a clinic for employment managers a man was presented who was a competent draftsman. He had come to the hospital because he felt unable to do good work and "as if he

could not keep it up any longer." One of the employment managers said he thought this man ought never to have been in the Psychopathic Hospital, that he was "just like everybody else." But the physicians found in him many temperamental difficulties of a well recognized psychopathic nature, and when they treated the patient from this standpoint, he at once showed decided improvement.

Social workers have here, in the early discovery of psychopathic conditions, a boundless opportunity for mental hygiene. In addition, we have the opportunity, by applying the simpler rules of mental hygiene, to promote the mental vigor and mental development of individuals who do not require the care of a physician but are not as competent as they might be. Wrong habits of thought, badly trained emotions and instincts that may never cause a condition warranting medical attention, may interfere seriously with the happiness and usefulness of an individual. It is the duty of the social worker to attend to these things as well as to matters of diet and hygiene. After a fashion we make the attempt to do so, but as a rule without any exact knowledge of psychology and psychiatry.

Another product of the psychiatric point of view is the habit of objective observation—the study of an individual as he really is, not as we feel that we should be in his place, or as he himself tells us that he is. In social case-work we need to know as accurately as possible the nature of our client. We do him an injustice if we form a conception of him in terms of our own experience. His own account, though honestly meant, may not be accurate. Through observation of his behavior and reports of other observers upon his conduct, the best account of his character is to be obtained. When we come to the point of trying to understand him, we must necessarily think in terms of our own experience, but the objective study should precede the interpretation. We should first find out what an individual is like, and then think how we should feel and act if we were like that. This process of objective study, preceding subjective understanding, simplifies many problems in social work and promotes sympathy with our clients. Personalities quite unlike our own when studied objectively become comprehensible. We are even able to enter into experiences of psychopathic persons unlike anything that we have ever known. Not only is understanding of the individual a requisite of good case-work, but also the individuals with whom we are dealing are

apt to feel the difference between genuine and assumed sympathy, so that any gain in better understanding is of great value in securing their confidence.

Another result of studying individuals from the psychiatric point of view is greater respect for their personality. When you recognize the fact that human nature is not to be rated at certain levels of merit, but is subject to infinite variations of ups and downs in character, you come to feel more respect for the high spots in even the most unsuccessful individual. If at the same time you recognize the natural causes that lead to failure you regard the individual without blame. Many unfortunate psychopathic patients, who have been censured and despised by their acquaintances, and sometimes I fear by their social workers, feel a great sense of relief when they find themselves taken from the psychiatric point of view, and with renewed self-respect do their best to improve their conduct.

One by-product of the psychiatric point of view in social casework is worth consideration in these days of overworked social workers, that is, the greater ease in work that it gives the social worker. The strain of dealing with unknown quantities is perhaps the greatest cause of fatigue in our work. The better we understand our cases the more readily and confidently we work. More exact knowledge of the personalities with which we are dealing, not only saves the worker worry and strain but also releases energy which can be applied to treatment. Besides, we know that the more our clients realize that we understand them the more we can do for them. Another result of understanding the natural causes of vexatious conditions is that impatience is almost entirely eliminated. No time is wasted upon annoyance or indignation with the uncooperative housewife, the persistent liar, the repeatedly delinquent girl. A small dose of reproof may be administered occasionally for therapeutic purposes, but as a rule no variety of impatience is of value in social treatment.

I have known social workers who looked with suspicion upon the careful preliminary study of personality, because they feared that all of the worker's interest might go into the analysis, and that treatment might be neglected. I believe this fear has been something of a bugaboo in social work. It is an unfortunate mistake to regard careful thinking as inconsistent with vigorous action. To be methodical is not to be mechanical; to be scientific is not to be less humane; to be thoughtful is not to be unfeeling.

These ideas are sometimes carelessly contrasted to the discouragement of better methods. We need more thinking in social case-work. In medicine if the diagnosis is plain the treatment is usually clear. In social work if our analyses were more exact, the treatment would be more plainly indicated. We owe it to our clients to bring to bear upon their cases the best thought we can give and the most exact knowledge we can obtain.

It is now the generally accepted view that some knowledge of psychiatry should be part of the education of all social workers, and not confined as at present for the most part to social workers who deal with nervous and mental cases. This principle is now in operation in several schools of social work where a course in social psychiatry is required of all students. The future social worker, as I read the signs of the times, will have included in her professional education some knowledge of all the different branches of social work—psychiatric social work, medical social work, family rehabilitation, child welfare, community service. In three years of graduate work it would be possible to give instruction in all of these subjects with a year of practice in one or more fields. At present the need for workers in special fields is so pressing that we are forced to prepare students immediately for one or another type of work. Let us hope that it may not be many years before social workers will be required to have a broad general preparation comparable in content and discipline with training courses for other professions. Specialization afterwards is to be expected, according to individual aptitudes and interests. There will no doubt still be the psychiatric social worker whose purpose is to assist the psychiatrist in the care of mental cases and the investigation of mental disease. But the trained social worker of the future in all fields will know enough of social psychiatry to deal with the mental factors of social maladjustment.

MENTAL DISORDER CONSIDERED AS A PSYCHOLOGICAL REACTION.

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OF recent years psychiatrists have been turning their attention to the part played by mental factors in the causation of mental disorder. This field of investigation, however, is so extensive and has been so recently opened up that, notwithstanding the valuable work already done, it remains for the research worker practically virgin soil. There appear to be a great variety of mental causes from which a psychosis may develop and an understanding of these causes can only come from the study of a large number of cases. There is one principle, however, which applies in every case; that is, that the psychosis is the patient's reaction to some experience or series of experiences, to some situation in which he has been placed.

The causes which enter into the production of an abnormal type of mental reaction are of two kinds. On the one hand are the external causes, the more or less difficult situations which the individual may be unable to meet in a healthy way, and on the other hand, there are the internal causes, the defects in personality, the unwholesome tendencies which may lead him to react with a psychosis in situations which, to the ordinary individual, would present no serious difficulties whatever.

In no two cases are we likely to find that the situation or the psychosis to which it gives rise is exactly the same, although of course we do find certain general types of reaction which occur over and over again. The lack of uniformity in our cases is one of the things which makes it so difficult to draw conclusions in regard to them, for the conditions which give rise to the disturbance in one case are almost certain to be quite different from those which are found in the next.

In this article I shall present a rather simple case which shows one set of conditions out of which a mental disorder grew and which will serve to demonstrate the significance of the statement that a psychosis is a reaction to a situation.

The case is that of a young man who rather suddenly became moody and depressed and gave up work to spend his time in bed

or lounging about the house. He indulged in violent outbursts during which he talked incoherently and behaved in an irrational manner, his condition finally becoming so serious that it was necessary to commit him to a hospital. To his family his depression seemed to have come upon him out of a clear sky; they knew of nothing which could have produced it. An intensive study of the case, however, made the cause of the trouble quite clear by bringing to light the situation to which he had reacted with a psychosis and the defects in his personality which had caused him to react in this way.

The patient was found to be rather above the average in intelligence. In public school he had always stood at the head of his class. He had been quiet and studious in his tastes and was inclined to be rather shy and retiring. At the same time, he had a high opinion of his own literary abilities and was very ambitious. He wished to obtain a college education and dreamed of ultimately taking up literature as a profession.

Unfortunately he was also weak and self-indulgent. He desired to accomplish great things but was not willing to exert himself or to sacrifice his comfort in order that his ambition might be realized. Whenever he had encountered any difficulty or unpleasantness, he had always reacted, not by putting forth extra effort to overcome the difficulty, but by becoming discouraged and seeking to exchange the difficult situation for an easier one. For example, after two years in High School, he became discouraged because he was not permitted to map out his own course, but was obliged to give a good deal of time to subjects which were not interesting to him. This caused him to leave school and take a position as an office boy. Later, he secured a position in a library where the work was of a kind well suited to his tastes and abilities, but he gave it up when he was obliged to work after closing time in order to have things in shape for the next day. On another occasion, when he was advanced from a simple routine clerical position where the work was easy, to another which gave better pay and opportunities for advancement, he asked to be moved back to his old job because in the new one the work was heavy and he frequently had to remain after hours to finish it.

Although this tendency to self-indulgence may be regarded as to some extent a part of his original mental endowment, there were certain factors which contributed to its development. Of these, one was the sheltered conditions under which he had been raised.

He was the youngest of several children and had always been petted and indulged by the older members of the family. If he had been obliged to fight his way through his difficulties, to stand on his own feet, he might have developed more sturdiness of character. As it was, being indulged in his tendency to avoid always what was hard or unpleasant, this tendency grew stronger as the years went by. Another factor was his unwholesome attitude toward his work. His ambition was to become a writer. He was interested in philosophy, science and literature. He cared nothing for business and regarded the various positions which he held as mere makeshifts. He did not feel that in these positions he was occupying his proper niche. He dreamed of some day getting into the kind of work for which he was fitted and there achieving a great success. For this reason, he did not take his work seriously. He did not regard it as important and his efforts to succeed in it were only half-hearted. So, whenever he found it hard or unpleasant, instead of looking at the difficulty as only an obstacle to be overcome, he regarded it as evidence that he was in the wrong kind of a job and his tendency was to give it up and seek another position to which he would be better suited.

In such a case as this, we see how the high ambitions which are supposed to be a spur to increased effort may sometimes prove only a handicap. If this young man had been possessed of more force of character, his ambition might have led him to study in his spare time. He might have attended evening classes. In fact, if he had shown a strong inclination to study, his brothers would have given him the financial support necessary to enable him to return to school and go on with his education. Thus he might have fitted himself for the professional career of which he dreamed and his ambition might have carried him on to success. But there was a weakness in his own character which prevented him from doing this. He, himself, was apparently conscious of it for he said, "My aim was high but I lacked the ammunition to drive me; my lack was not ability but simply driving force." So he drifted along in a desultory way and his ambition, instead of inspiring him to higher effort, merely prevented him from taking a healthy attitude toward the simple tasks which were close at hand.

Having considered the type of individual with which we have to deal, let us now consider the circumstances which precipitated his psychosis.

Previous to his psychosis he had been filling an easy but poorly paid routine clerical position. He had long been dissatisfied with his position and had repeatedly asked for promotion to something better. He was finally given the long wished-for promotion and was at first very much pleased with it. But he soon began to encounter difficulties in his new work. Perhaps his most serious difficulty was due to the fact that he was obliged to make out elaborate reports and statements. The data for these he had to obtain from the books of the various departments of the company in which he was employed. He had not sufficient familiarity with the bookkeeping methods in these departments to find the information for himself and, consequently, had to apply constantly to his fellow clerks for assistance and advice. He was shy and sensitive. He hated bothering people. Moreover, he felt that if he asked so frequently for assistance he would give the impression that he was not competent and was getting others to do his work. Therefore, when he had a report to get out which necessitated asking for information from people he had already been bothering a good deal, he would not have the courage to go to them. He would simply postpone getting out the report. Thus it was that, as the days went by, one neglected task after another piled up on him. He got farther and farther behind in his work and as the pile of neglected work grew larger he became more and more discouraged. He saw that he was not making a success of his new position. He knew that he could not hope to retain it unless he did better work. He went about daily with the dread hanging over him that his employers would discover how badly he was doing and that he would be severely reprimanded, perhaps discharged.

A man with any force of character, at this point, realizing into what a hopeless muddle his weakness and negligence had led him, would have pulled himself together, attacked the neglected reports and again gotten his affairs into good shape. But the patient was not such a man. As he, himself, said, he had lost heart and it had always been impossible for him to work at anything if his heart were not in it. It was quite characteristic of him that he should attribute his failure in this position, not so much to his own weakness as to the complicated system of bookkeeping which made it difficult to obtain the information required and to the fact that in any case the position was not one to which he was suited. So he simply marked time in his work, becoming

every day more anxious and depressed. He would have given it up altogether, in spite of its opportunities for advancement, and have gone back to his old routine job, but another man was now filling the old place, thus cutting off that line of retreat. After a couple of weeks in his new position, he had his annual vacation and this afforded him a brief respite, a short two weeks, during which he was able almost to forget his troubles. But when his vacation was over and the morning came for him to return to work, he could hardly get himself out of bed and drag himself back to the office. Arrived there, he had no heart to attack the accumulation of tasks awaiting him; so he simply "loafed on the job," and "made a bluff at working"; then, after a few days, as the situation had become intolerable and as he felt that sooner or later he would be discharged in any case, he resigned his position, telling his employers that he was leaving the city.

By the time he gave up his position he had become very depressed. He had not only worried over the difficulties in his work and the fact that he was not making a success of it, but also over the possibility of having to give up his position and being unable to procure another. Having gotten into a depressed and anxious state of mind, he began to brood over things that previously had given him little concern. As he, himself, said, "One depression started another. Thinking about one thing started me thinking about something else. You can easily find things to worry about when you look for them." So it was that he began to brood over the fact that with all his fine ambitions he had been making nothing of his life, that his life in the past had been colorless, with few real pleasures and practically no friends. Being in this depressed state of mind, he had very little heart to go out and look for another position. Yielding, therefore, as always, to his inclinations, he spent most of his time at home either lying in bed or lounging about the house, not even taking the trouble to put on his clothes. He remained at home about five weeks, during which time he slept poorly, cried a good deal and at times worked himself up into an emotional condition in which he threatened to commit suicide, talked incoherently and "acted crazy." His crazy actions apparently consisted of gesticulating and throwing himself about in an emotional state that bordered on frenzy.

He now says that in acting and talking as he did he was only feigning insanity. He wanted to make the family realize how

bad he felt. He evidently believed that he was telling the truth when he made this statement and it seems to have some basis in fact, for, although his behavior was undoubtedly an expression of genuine emotion, it is probable that he made but little effort for self-control, that, on the contrary, he endeavored to express his feelings as violently and extravagantly as possible. Two motives lay back of this. One was the demand for the sympathy which he hoped to arouse by his extravagant manifestations of distress. The other was a desire to justify himself in the eyes of his family for remaining at home idle, a burden for them to support. He himself felt that he was in a nervous and emotional state which rendered him unfit to go to work and he wished to make his family realize this by demonstrating to them what a bad condition he was really in.

Evidently he was at this time the victim of conflicting impulses and desires. On the one hand, there was his need for emotional outlet and the demand for sympathy and self-justification which impelled him to give way to the frenzied outbursts in which he talked and behaved in such an extravagant manner. On the other hand, he was impelled to inhibit these outbursts both from pride and from consideration for his family, for it was humiliating to be regarded as insane; moreover, he realized that by giving way to his emotions in this manner, he was bringing upon his family a great deal of anxiety and distress. The result was that his conflicting impulses swayed him now this way and now that. At times, actuated by one set of impulses, he would indulge in an emotional outburst, but later, when he heard members of his family discussing his condition, he would be ashamed and sorry and feel worse than before. Finally a physician was called in who said that his mind was affected and advised sending him to an institution. The patient was now feeling so ashamed and distressed by the fact that his family regarded him as crazy and by the trouble he had brought upon them, that the home situation had become intolerable. He therefore welcomed the doctor's suggestion as offering a way of escape from it. His own word's make his attitude in this matter fairly clear. He said, "My sister's children came around and saw me doing all sorts of queer actions. I knew what I was doing. But the poor children! I liked them and I always played with them and they thought their uncle was crazy and I felt ashamed of myself and I wanted to go away to Bellevue for about a week." At his own request, his brother took him to

Bellevue. When he expressed a desire to go to a hospital, he did not regard himself as really insane and did not think that he would be committed. He said, "I did not think they would regard me as insane. I thought I would be given good advice and allowed to return home after a few days. Instead of that, they treated me as an ordinary routine case of insanity."

From Bellevue he was committed to the Manhattan State Hospital, Psychiatric Institute Service. On admission, he discussed his case with the physician with a good deal of frankness. He was grateful for the advice which he received, but was not willing to remain in the hospital even for a short time and begged for his discharge as offering the only means of recovering from his depression. He was full of self-pity, bemoaned his folly in having asked to be taken to Bellevue, saying that if it had not been for this he would never have been brought here. He was continually appealing to the physician and to his relatives for sympathy. He spent a good deal of the time exercising his literary talent in the composition of letters to different members of his family which were calculated to work upon their feelings so that they would secure for him his speedy release. The following from one of his letters is fairly typical—"I am suffering indescribable agony and feel that my heart is actually breaking from having to stay among this class of people. . . . I am slowly but surely sinking into an unforeseen state. . . . Have me taken home, that sweet home, I never was away from it before."

He remained in the hospital for about six weeks, during which time he improved considerably, and was finally allowed to leave because his family were anxious to take him away.

Now this case affords a concrete example of what is meant by the statement that a psychosis is a reaction to some situation. In this case, it has been shown that the trouble commenced when the patient began shirking the difficult and unpleasant tasks in the new position to which he had been advanced, this being for him a characteristic type of faulty reaction as he had always been weak and self-indulgent. It has been shown how this led to his work's getting into a very unsatisfactory state, creating a situation to which he reacted by becoming anxious and depressed, finally giving up his position and remaining idle at home, brooding over his trouble and giving way to outbursts of emotion which were also appeals for sympathy and attempts at self-justification for his weak and self-indulgent behavior. And so on throughout the

history of the case, it has been shown how his emotion, thought and conduct have been his reaction to the situation in which he was placed and how this reaction has been in keeping with the type of personality which he has always shown himself to be. The psychosis would seem at first sight to be something which had fallen upon the patient out of a clear sky. But, when we know the kind of a person he was, the experiences through which he had passed and the conflict that had been going on in his mind, we can see that his thought and conduct have been nothing more than what might have been expected from such a person under such circumstances; in other words, that his psychosis has been his reaction to the situation in which he was placed.

The case is a very simple and commonplace one; the forces to which the disorder is due have operated at a conscious level; there is no elaborate symbolism; but it is no less deserving of attention on that account. It is the commonplace type of case with which we most commonly have to deal and which, therefore, affords a most important problem in mental disease. Moreover, because it is very simple, it serves to demonstrate all the more clearly those fundamental principles of which, in the more complicated cases, it is so easy to lose sight.

One important principle to be kept in mind is that the pathological is always an outgrowth of the physiological. The key to the abnormal is always to be found in the normal. A very useful conception which psychology has given us concerning the normal mind is that it is a mechanism for producing useful reactions to the various situations in which the individual is placed. For example, when a man is placed in a position of danger, he will react with a feeling of fear and an impulse to escape, or when faced with some difficult situation, he will use his reasoning powers to discover the best way to deal with it. Now a psychosis may be a reaction of essentially the same type as that which occurs in a normal individual, only differing from it in the fact that it is a faulty one.

But why should we get faulty reactions? Why does not everyone react always in a normal way? There are probably various factors which go to determine the individual's reaction to a given situation, but of these the most important one is the mental make-up of the individual, the mental qualities with which nature has endowed him. No two minds are exactly alike nor can be expected to react to the same situation in exactly the same way.

Take the reactions of different men to the situation created by the entry of this country into the world war and the demand which it made upon them for military service. No other event perhaps has brought out so strikingly the different ways in which different individuals react to the same situation. One man reacts by rushing off to enlist, all eagerness and impatience to get into the fight. A second awaits the call to arms, hoping he will not have to go, but ready and willing if the call comes to make any sacrifice his country may require of him. A third whines and grovels and resorts to every device and subterfuge to escape being drafted, while a fourth reacts with such a profound emotional disturbance as to necessitate confinement in an institution.

The faulty types of reaction are only normal types wrongly used or carried to excess. Fear and the tendency to avoid personal danger constitute a useful type of reaction to certain situations, but they are out of place when a country is calling upon its men in the hour of need. The tendency to become discouraged and give up in the face of difficulty is a useful type of reaction when it prevents one wasting time and energy in attempts to accomplish the impossible, but it becomes a faulty type of reaction when, as in the case here presented, it is carried so far as to cause a man to give up his work whenever he encounters anything hard or unpleasant.

It is necessary in this connection to remember that a mental reaction, whether normal or abnormal, is not merely an act performed by the mind, but that it also involves a change in the mental state. This change may be chiefly emotional, as when on suffering some serious loss the mood changes to one of depression. It may be a change in one's mental attitude toward some person or thing as when, after receiving ill-treatment at the hands of some person, the attitude toward him becomes one of antagonism and dislike. Or again, it may consist of the development of new beliefs or the modification of old ones as the result of experiences through which one had passed. When we speak of a psychosis as a mental reaction to a situation, we have in mind, not so much the behavior with which the individual has reacted to this situation, as the underlying change which has taken place in his mind; for example, the depression which has resulted or the false beliefs which have been developed.

But if we get the same types of reaction in both normal and abnormal mental process, what is the difference between them?

What distinguishes the normal from the abnormal? As a matter of fact, there is no sharp dividing line. No one can say where the one ends and the other begins. There are a large number of borderline cases where it is doubtful whether the reaction should be classed as merely an unhealthy one, or whether it should be regarded as a psychosis. For example, in the case here described, the patient's reaction does not differ very much from those forms of thought and conduct which we see in presumably normal individuals. To become depressed and to give up in the face of difficulty, to yield to outbursts of emotion, these are reactions we have all indulged in to a greater or less degree. It is only when, as in the present case, these reactions are carried to such an extent as to render the individual unfit to fill his appointed place in society, that they are to be regarded as abnormal.

In conclusion, I would like to point out that, since the psychogenic disorders are simply the reactions of human beings to situations in which they are placed, we can easily see why they present such an infinite variety in their clinical pictures and why they are so hard to classify. Every psychosis is a product which results from a certain type of personality reacting to a certain situation, but as in no two cases is either the situation or the personality quite the same, so in no two cases can we expect to find exactly the same kind of psychosis resulting. To be sure there are certain general types of abnormal mental reaction to which our cases conform in a greater or less degree, just as there are general types of normal reaction, and it is not unlikely that, when we have acquired a fuller knowledge of these fundamental reaction types, they will form the basis of a better system of classification than any we have at present. But no matter what system of classification we may adopt, we need never expect to find any definite lines of cleavage dividing our cases into distinct groups, any more than we need expect to find a definite line of demarcation separating the abnormal from the normal.

MENTAL DISEASE IN FAMILIES

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THE classical doctrine on the transmission of mental disease is that of the French school and notably that of Esquirol and Morel. This doctrine affirms that all forms of mental disease and a large number of nervous disorders together with some constitutional states are various and interchangeable manifestations of hereditary degeneracy. Thus, the doctrine assumes that such varied diseases as idiocy, cretinism, moral insanity, hebephrenia, catatonia, mania, melancholia, involution and senile diseases, neurasthenia, hysteria, epilepsy, criminality, and eccentricity in all its thousand and one forms, are not really separate conditions but merely manifestations of one condition: to wit, inherited and inheritable degeneracy. Some French writers have even included in this group tuberculosis, alcoholism, and rheumatism. The French doctrine holds that the lighter forms of degeneracy appear in the first generation as eccentricity in its protean forms of "self-centered narrow-mindedness, fanaticism, spiritism, and unwholesome contempt for traditional objects, anti-crusades of all kinds, miserliness, spendthrift ways" or neurasthenia and the related diseases. In the second generation the nervous disorders are more accentuated—severe hysteria or epilepsy or periodic psychoses with more marked disturbances and true paranoia. In the third generation there are more severe psychoses which start earlier and end in profound dementia. The fourth generation sees the ending because the idiots, hebephrenics, etc., who comprise it, cannot propagate.

Most eminent psychiatrists have, at least in part, approved this theory of degeneracy. The French have practically all accepted it and the English generally. In Germany there is a division, but nearly all the older psychiatrists, for example, Griesinger, Schule, Krafft-Ebing, Ziehen, Möbius (who very trenchantly calls neurasthenia the "primeval ooze" of all degeneracy), Kraepelin (in his earlier writings), Bumke, Liepman, Binswanger, etc., give their approval. There is to be noted, however, another less well known group of German workers who have tried to show by actual

clinical studies of families in mental hospitals that family mental disease runs in groups of mental disorders which are related and which exclude other groups. Thus Sioli and Vorster declare that manic and dementia praecox exclude one another in heredity, to which Kriechgrauer gives assent. Less extreme than these, Jolly, Albrecht and Pilcz find that dissimilar heredity exists, but that the main trend is toward similar heredity and assume for the dissimilar a *Keimschaden*, that is, germ-plasm injury which is not a true heredity but, in a sense, congenital disease.

In America the question of polymorphism has scarcely been considered. So far as the writer knows, Rosanoff and Knapp are the only workers who have studied it, although practically every hospital history taken in America assumes it, since no attempt is made to differentiate the type of mental disease in the heredity. But with a few notable exceptions the specific problems have not received research attention. Davenport and his co-workers and Rosanoff and his have contributed the most to the subject—Davenport to the question of feeblemindedness and epilepsy and Rosanoff to clinical psychiatry. These two writers have worked entirely from the standpoint of Mendelism and their efforts seem to me to be directed not so much to discover the laws of the transmission of mental disease as to fit the facts to Mendelian theory. To do this with any show of plausibility it has been necessary to divide mankind into two types—the normal and the neuropathic. It is assumed that the neuropathic differ from the normal by the lack of some normal determiner. There is no evidence brought forward to substantiate this view and it is just as reasonable to assume that a diseased or new determiner is at work. Moreover, it is premature, to say the least, to assert that all the different forms of mental abnormality (feeblemindedness, epilepsy, criminality, etc.) are related to a unit determiner, or group of determiners, for the laws of Mendel have not been shown to apply for any single normal human character of simple type, except perhaps eye color. As we know that normality is an *abstraction* rather than an *entity* it is at present presumptous to relate all changing forms of normality to a unit group. Furthermore, I question whether a true Mendelism has been followed. The dominant characters of Mendel appear in a first generation through the mixing of two stocks, and in the second and later generations the proportion of recessive and dominant appears through the inbreeding of the first generation; that is to say, what would correspond to the mating of brothers and

sisters in human relationships. No such conditions prevail in mankind, and expectations of ratios and proportions seem futile.

As a contribution to the question of the heredity of mental disease a study was undertaken of the families represented at the Taunton State Hospital. Realizing that some of the descendants of patients become themselves patients, but that *the great majority do not*, we had hoped to be able to study the questions: What happens to these last, that is, those descendants of patients who disappear into society? What is their fate? Do they give evidence of a progressive degeneration or of a regeneration, or of both? How do they succeed in life? In how far do they contribute to society's problems—mental disease, criminality, feeblemindedness, pauperism, disease? Since lack of financial assistance made the study of these larger questions impossible, the problem was attacked for the time being along simpler lines.

The Taunton State Hospital was opened in 1854. A survey of the record of patients shows that from 1854 to January, 1916, there were 22,300 admissions to the hospital. From a rough calculation made by analyzing 3,000 records taken at various points in the history of the hospital, it seems that about 16,000 persons are represented in the 22,300 admissions. Of the 1,300 patients in the hospital at the time the survey was made, roughly 10 per cent were related to one another. Of the patients that had been in the hospital from 1854 to 1916, there were 1,547 who were related to one another and these represented 663 families. The records of these related patients were analyzed, field work was done in a great many instances and all the patients then in the hospital were re-examined and interviewed. It is realized, of course, that because of changing psychiatric viewpoints, of differences existing in individual records and of the liability of error and misstatement in personal opinion as to diagnosis of mental cases, the use of the old and even of the new records is unsatisfactory. Still, it was possible to obtain from such a study a considerable body of fact that is significant in its bearing on present and past theory of the heredity or transmission of mental disease, on the social relationship of the insane, and on the proper plan and method for further study of the transmission of mental disease. A full report of the data obtained, together with family histories and individual case studies, has been made elsewhere.*

* Psychiatric Family Studies. By Abraham Myerson. *American Journal of Insanity*, vol. 73: p. 355–486, January 1917; and vol. 74: p. 497–554, April 1918.

In order to make the results more easily accessible for consideration and criticism there is here presented only an outline of such tentative conclusions as seemed warranted by the data.

It is to be emphasized that the results presented, though fragmentary in their bearing upon the transmission of mental disease, have the merit of being based on hospital cases, studied and recorded by hospital men. The fundamental effort has not been to produce a theory of the inheritance of insanity, which in my opinion is at present a futile matter, but to make predictable, family mental disease. The problem may be formulated by two questions:

1. Given an insane parent with a definite type of mental disease, *if he has insane descendants*, what type of mental disease may we expect in those descendants? (It is emphasized that he *need not have* any insane descendants just as normal people *may have* insane descendants.) This question concerns what I have called the vertical aspect of mental disease, that is, its change from generation to generation.

2. Given an insane person with a definite type of mental disease, if he has insane brothers or sisters, what type of mental disease may we expect in those brothers and sisters? Here again it is emphasized that these insane persons' fraternity may be entirely normal. This question is the horizontal aspect of mental disease.

The answers to these two questions will be considered, but it may be of interest to take up first a few related points.

THE NEUROPATHIC HEREDITY OF THE INSANE AND NON-INSANE

This question has not been personally studied. The conclusions here stated are taken from the only two important studies on the subject, those of Koller and Diem. A few of their data are to my mind clear-cut enough to be important.

1. There is very much general neuropathic heredity in the direct and collateral relatives of both the insane and sane.

2. There is far more insanity in the families of the insane, and this is especially true of the parents and grandparents of the insane.

3. Insane uncles and aunts occur about as frequently in the families of the sane as in those of the insane; therefore, collateral insanity is of relatively little importance unless associated with parental insanity.

4. The sane seem to have as much, or even more, of nervous

disease, senile dementia and apoplexy in their ancestry. This would throw out of court as useless, the questions as to nervous disease, apoplexy, etc., in insane hospital histories. It would entirely vitiate the value of such works as Davenport, in which apoplexy is considered a neuropathic taint when, as a matter of fact, the question is entirely arterio-cardio-renal.

MARRIAGE RATE OF THE INSANE

In the four groups studied personally, including males and females,—alcoholic insanities, general paresis, dementia praecox, and senile dementia—we find first, that the males in the alcoholic, paretic, and dementia-praecox groups marry less than do the females. In the seniles, although the percentage of married men is greater, the totals of those who have entered conjugal relations at one time or another are about equal. Looking somewhat closer, it is found that in paresis there is only a slight difference in favor of the female, while in dementia praecox this difference is much further increased; thus, if these groups may be held to constitute a menace by virtue of their ability to transmit the psychotic taint to another generation, the female of the species, to use a well known phrase, is more dangerous than the male.

The seniles and the general paretics marry but slightly less than do the same age-groups in the total population; the alcoholics show a decided falling off as compared with the total population; while the male dementia praecox has an exceedingly low marriage rate. That is, *whatever is back of dementia praecox, it operates against self-perpetuation*. Something of the same internal mechanism is seen in the case of alcoholism. This mechanism operates very little, if at all, in the case of paresis and the senile psychoses. One might conclude that if there is an inborn defect in these diseases it is by far greatest in dementia praecox, is next in alcoholic insanity, and least of all in syphilis and the senile psychoses.

We are shown that marriage acts as a barrier to the propagation of the abnormal in so far as this is connected with endogenous factors. It is not a barrier against certain of the exogenous race poisons, such as, for example, syphilis, at least in that form which leads to paresis. We need to strengthen the barrier against the endogenous diseases, as for example, dementia praecox, but not nearly so much as we need to strengthen it against the exogenous, as, for example, syphilis.

GENERAL STATISTICS

For the purpose of comparison, figures obtained by Mott in his studies have been included in the following summary.

1. More females than males are concerned in family psychoses. The studies at the Taunton State Hospital showed 808 females and 739 males.

2. The mother-daughter group is much more common than the father-daughter group—80 to 59, as shown by the Taunton figures; 137 to 103, as shown by Mott's figures.

3. The mother-son groups are about equal.

4. Mother-son and father-son are about even—56 to 59, in accordance with Taunton figures; 96 to 88, as shown by Mott's figures.

5. Sisters alone decidedly outnumber brothers alone—80 to 57 according to Taunton figures; 211 to 140, according to Mott's figures.

If insane women transmit their mental peculiarities to their female children more than they do to their male, then the greater marriage rate amongst insane women may decidedly play a part in determining the preponderance of insane women. Furthermore, men migrate more than women, and so in any given hospital district the female descendants of insane ancestors would be more apt to appear in the asylum than the male descendants even if given equal rate of incidence. That is to say, a larger part of these men would end in jails or in hospitals in districts remote from their former home, etc.

ANTICIPATION OR ANTEDATING

This term is used (Darwin) to describe the earlier appearance of mental disease in the younger as compared with the older generation. This phenomenon has been given great prominence by Mott and his co-workers. He regards it as an effort of nature to get rid of the disease by crystallizing it in a few descendants and making them more easily vulnerable or unfitted to propagate by being brought early to hospitals. There are thus in Mott's definition of anticipation, first, a crystallization of the insane elements leaving other descendants free from disease, and second, earlier onset of the psychosis in the affected members.

All of the figures, and especially in the second generation cases, seem to point clearly to the validity of the phenomenon of antedating or anticipation. A closer examination, however, shows one

great fallacy underlying the statistics and that is, as usual, the method of collection. In a majority of cases the period of time during which the cases have collected is not clear (for example, in Mott's statistics where no mention is made of the period during which his figures have been collected), but it is generally within 30 years. As the average ancestor is at least that much older than his average descendant, it would be practically impossible for the descendant to be older than the ancestor at time of commitment, and the age difference between ancestor and descendant would generally be from 33 years to zero, in favor of the ancestor, and in certain cases where the descendant enters the hospital before the ancestor it would be 30 years or more. This means that in the cases of some of the investigators it has been possible for the younger descendants to enter the hospital, but time enough has not elapsed for the older descendants to arrive. As the Taunton figures have been collected since 1854, this objection does not obtain with such force. Nevertheless, the rate of commitment has increased within the last generation, so that even in my cases the bulk of families has arrived within the last 30 years and thus the factor stated above still plays its part in falsifying the manifest results.

It is probable, therefore, when all is said and done, that in a very large proportion of cases the descendants of the insane who themselves become insane do so at an earlier age than their ancestors. Moreover, as is well known, these descendants have a much lessened chance for marriage and so this factor of anticipation seems to be, as Mott believes, a potent factor for race regeneration through elimination. One need not, of course, subscribe to any such anthropomorphic absurdity as that nature has any intentions in the matter. It is perhaps better to speak of this phenomenon as the downward trend of psychiatric families just as the sane descendants represent their upward trend.

TRANSMISSION OF INSANITY

With reference to the vertical aspect of insanity:

1. Given a paranoid type of psychosis, including in this term true paranoia, paranoid dementia praecox and unclassified paranoid states, what types of mental disease may we expect in the descendants? The answer is definitely that we may expect either paranoid disease or ordinary dementia praecox in the insane descendants, and this statement is corroborated by Jolly, Luther,

Krueger, Rosanoff and Albrecht. Practically no manic-depressive descendants appear.

2. Given well defined dementia praecox in an ancestor, what type of mental disease may we expect in the descendant? Dementia praecox follows in the large majority of cases. Feeblemindedness of a type which is perhaps very early dementia praecox is relatively common. Epilepsy is noted. Manic-depressive insanity occurs very rarely if at all.

3. Given a well defined manic-depressive insanity in an ancestor, what type of mental disease may we expect in the descendants? There appear to be two main trends, one towards manic-depressive insanity and the other towards dementia praecox. Difficulties in diagnosis play a large part in solving this particular question, but it is certain that short attacks of mental disease bearing the earmarks of manic-depressive in an ancestor are followed in insane descendants by a definite dementing psychosis corresponding to what this uncertain generation calls dementia praecox.

4. Given an ancestor with involution psychosis, what type of mental disease may we expect in the insane descendant? It seems to be universal experience that dementia praecox follows involution psychosis and that apparently no matter what the type of the involutional insanity.

5. Given an ancestor with senile psychosis, what type of mental disease may we expect in the insane descendant? The Taunton figures, as well as those of Vorster, Albrecht, Jolly, Luther and Krueger, all find that what is termed "senile dementia" is of such heterogeneous nature that what might be expected, occurs; that is, dementia praecox, manic-depressive, paranoid psychoses, imbecility and epilepsy, all are found in the insane descendants.*

If then, we survey the facts which have here been presented together with the trends observed in the literature, we find that the paranoid and catatonic diseases trend finally to dementia praecox; that manic is succeeded by manic and in a varying proportion of cases by dementia praecox; that the senile and involutional psychoses, if paranoid, or more properly involutional and senile, trend towards paranoid diseases and dementia praecox. Manic states of the senium follow the rule of manic states elsewhere. Neither for organic brain disease nor alcoholic psychoses can anything very definite be said, except that in the cases studied, wherever adequate history has been obtained, the psychosis in the descendant of the alcoholic or of the patient with organic brain

* Op. cit., page 480, gives a fuller discussion of the senile psychoses.

disease can be related to some other more definite psychopathic feature than either alcoholism or organic brain disease. *It will thus be seen that all roads seem to lead to dementia praecox and from thence to imbecility.*

With regard to the horizontal transmission of insanity, it may be thus restated: Given an insane person, what psychosis may we expect in his insane brothers or sisters?

1. The psychoses of brothers and sisters tend on the whole to be of similar type.

2. If one brother or sister has dementia praecox, the chances for dementia praecox in any other insane brother or sister is very great. Feeblemindedness, or what is called feeblemindedness, occurs frequently. This, as has been before stated, may merely be congenital dementia praecox with dementia as the leading feature.

3. Manic-depressive insanity and dementia praecox are said to occur together in the same family group of brothers and sisters. Such cases are usually atypical, and really clear-cut cases with such association are rare.

OTHER ASSOCIATIONS OF INSANITY

With reference to the relationship between insanity and genius, it may be stated in answer to the question, how far is genius related to insanity, that the Taunton families would indicate that it is not directly related, for no genius and no high-grade talent of any kind has appeared prominently in any of the family groups studied, despite the fact that the district is the one in which the earlier settlers of the United States first appeared and from which many of their talented descendants have spread throughout the country. It is, of course, true that many geniuses have been insane. It is also true that the world has very largely followed insane persons and has mistaken their insanity for genius. It is probably true that insanity tends more to low-grade mentality and feeblemindedness than it does to genius and talent.

An interesting matter is the relation of tuberculosis to insanity. We have the statement of Heron that tuberculosis and insanity are closely related, a conclusion he has reached through a statistical study. This is, in a sense, an accepted conclusion, since most hospital historians usually inquire into the incidence of tuberculosis in families. My own records and charts show it to be very common amongst the fraternity, etc., of the insane and quite frequent in their ancestors.* Nevertheless, since tuberculosis is the most

* Op. cit., families 2, 11, 19, 25, 29, 37, 43, 66, 70, 83.

common of diseases, one should be careful not to mistake coincidence for a closer relationship. Certain facts show that its spread is by no means coincident with the spread of mental disease. The white plague has a very disproportionate incidence amongst the poor, whereas insanity shows no such tremendous predilection for poverty. Tuberculosis kills in the early years of life, whereas mental disease gains in frequency in the later decades. Racial stocks particularly prone to tuberculosis, for example, the American-Irish, show no greater amount of insanity if as great as stocks with very much less tuberculosis; for example, the American-Jewish. It is very likely that the insane, their fraternity, ancestors, and descendants are more apt to live in social conditions predisposing to tuberculosis than are the non-insane.

Criminality in the families here studied has been a very inconspicuous feature. It is true that certain of these insane have committed crimes while insane. That, however, does not make them criminals, since the crime was brought about by insane delusions, etc. Criminal relatives either in the fore or after generations have been infrequent. This may be due to the social conditions of this community. It is my belief, apart from facts which can be demonstrated in this study, that criminality stands in closer relationship to forms of feeblemindedness and alcoholism than it does to insanity. This, however, is certainly a matter which cannot be settled by insane hospital cases.

CONCLUSION

It may be stated again that we are not ready for any theories of heredity in the psychoses, for the fundamental reason that we have not reached a resting point either in our knowledge of the psychoses or in our knowledge of heredity as applied to man. It may well be that the psychoses represent disease processes rather than true heredity. It may be that they represent abnormal variations unfitted for survival in the world as it is at present organized, and that insanity in some of its phases is merely an excessive variation along well marked character lines, that it is a disease or abnormality merely by excess of variation rather than by defect of any character. What needs to be done is the establishment of an organized research carried along several definite lines, for example:

1. The study of the descendants of syphilitics, whether those syphilitics have been insane or sane, or have had neurosyphilis or not.
2. The study of the descendants of alcoholics.
3. The study of the descendants, normal and otherwise, of the insane confined in hospitals.

HOW TO AVOID SPOILING THE CHILD*

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I AM going to say a little about the way the mind develops in human beings and in higher animals.

Biologically, the human being, like other higher animals, and lower animals, too, for that matter, is an organism striving toward certain ends. An organism is, biologically, something that strives to maintain its own life and to perpetuate and increase the life of its race, and the evidence of that striving is what we call the behavior of the organism. Behavior is the pursuit by living things of their own welfare and their own ends and purposes; it is the manifestation of striving toward ends.

We are conscious ourselves of our movements; our own behavior is associated with something that we call "mental," which goes on inside of us, and we come to the conclusion, on watching the behavior of other people, that they also must have something "mental" or "psychic" going on within them that is more or less like what goes on within us. So what we know about mind is based upon a study of our own behavior and its psychic concomitants and upon the study of the behavior of other people. We look into ourselves to see what happens in us when we behave, and we draw inferences regarding what happens inside other people when they exhibit behavior.

Through the work of the comparative psychologists we have learned much about the innate disposition of living animal organisms; the innate traits of mind, the things upon which behavior depends. The so-called instincts have at least three sides to them; they involve not only (1) impulses toward gaining the ends that the instincts subserve, but also (2) feelings, or sensation, of being affected, at the same time, and also (3) cognitions. To use McDougall's terms, in the exercise of an instinct there is "a knowing, a feeling and a striving."

I may mention a few of the more common instincts, well known to everyone: (1) the nutritive instinct, associated with the feeling

* Remarks made at the 112th annual meeting of the Medical Society of the State of New York. Acknowledgment should be made of our indebtedness to the editor of the *New York State Journal of Medicine* for permission to reprint this article, which was originally published in the March, 1918, number of the *Journal*.

of hunger and the impulse to take food; (2) the motor instinct, in young children to crawl and to walk; (3) the instinct of flight, when we recognize that we are in an unfamiliar situation or in danger; it is associated with the emotion of fear, and with a tendency to flee or hide; (4) the instinct of repulsion; for instance, if we taste something bad in our food it excites disgust; (5) the instinct of curiosity, where we see something similar to something we have seen before, and yet a little different from it; this makes us wonder and we have the impulse to approach it cautiously and to examine it to see what it is like; (6) the instinct of pugnacity, that comes into play whenever our impulses are opposed in any way; we are excited to anger and we try to remove the obstacle, or, if we cannot remove it, we try to destroy it; (7) the instinct of self-abasement, which becomes active when we see people whom we think may be superior to us; we often have a feeling of submission or of subjection to them, and we try to make ourselves less obvious and may even slink away and try to hide ourselves; just the opposite occurs with (8) the instinct of self-assertion, when we are in the presence of spectators whom we think may be inferior to us; we tend then to have a feeling of elation, of well-being, and an impulse to boast; (9) the parental instinct, which is excited at the sight of a child, or the sight of weakness; thus, to see cruelty inflicted on the weak excites in us a tender emotion and the impulse to protect, to cherish, to help; (10) the sexual instinct, which is concerned when the sight of one of the opposite sex (under certain circumstances) excites the feeling of lust and the impulse to approach, to fondle and to embrace; I might mention also (11) the instinct of acquisition, and (12) the instinct of construction; and there are probably still others. These are at least some of the instincts that the comparative psychologists have studied and made us familiar with. They are the innate traits with which all begin life, and our higher mental qualities and our total behavior are built upon the basis of these simple fundamental instincts. Gradually, through multitudinous knowings, or cognitions, we acquire a body of "knowledge," and through multitudinous feelings and strivings we acquire what we call "character." Knowledge and character are built up out of the workings of the simple instincts.

A word as to the nature of the "sentiments." These are very complex things; they represent associations of cognitions, with feelings and strivings. In other words, sentiments are complex

feelings related to certain objects; we "love" certain things and we "hate" certain other things. For instance, the love of a child is a sentiment; the love of virtue is a sentiment; a love of power is a sentiment; the love of a church, the love of America and the love of the American flag are sentiments. We gradually develop also sentiments of hate. We learn to hate dirt; we learn to hate vice; we learn to hate disorder, and in this war we learned to hate German militarism.

Most important, perhaps, for social life is the development of what has been called the self-regarding sentiment—what is known as self-respect; this is not merely pride or self-love in the narrow sense. Self-respect is based largely upon a combination of the activities of two instincts, that of self-assertion on the one hand and that of self-abasement on the other. It includes the disposition of "negative self-feeling," and also that of "positive self-feeling." This self-regarding sentiment has had much to do with the origin and maintenance of social customs and with the development of the higher kind of conduct of human beings.

Obviously among so many tendencies and impulses there must be a tendency to conflict, and unless we learn how to organize the lower instincts into sentiments and to organize the sentiments into well-directed aims and purposes in life, we shall have mental conflicts and loose, dissociated personalities. It is very necessary that the instincts and the sentiments should be organized into a unified mental life.

The education of a child, then, includes education in self-expression and education in self-control. A certain amount of repression of the impulses is necessary. The child must learn properly to repress, and the reasons for this. Of course, there are very bad forms of repression as well as good forms of repression. Doctor Healy will perhaps tell you that it is essential that each one learn how to repress in a proper way in order that he may not have a chaotic life.

As McDougall has well said, there are four levels of conduct; (1) the level of instinctive behavior, modified by pains and pleasures incidentally experienced; (2) the level of behavior that is modified by rewards and punishments in the social environment; (3) the level of behavior that is modified by anticipation of social praise and blame, and (4) the level of the highest kind of conduct, in which behavior is regulated by an ideal of conduct, the person learning to do what seems to him right regardless of the praise or blame of his immediate social environment.

Behavior will obviously be dependent (1) upon the kind of instinctive foundation we possess—our hereditary traits, and (2) upon the environment to which the nervous system and the organism as a whole is exposed. What we inherit from our ancestors and the influence of things outside us after we begin to develop are the two great underlying factors of behavior. Heredity plays a very important part, just as environment does. There should be no quarrel between the advocates of the importance of heredity and the advocates of the importance of environment, for both are very important. There is no sense, it seems to me, in minimizing the importance either of heredity or of environment. At present it is true we can do more to modify environment than to modify heredity. But let us recognize the fact that heredity is equally important with environment in the development of organisms and their behavior and look forward to a future when we may wisely subject both factors to suitable control.

There can be no doubt that many of the psychopathic children, and many of the mental defectives that we see, are due to hereditary factors rather than to environmental factors. Thus, if two imbeciles marry, in the majority of cases all of their children will be imbeciles. Again, we all know how melancholia and mania tend to run in families; there is no doubt that the tendency to the manic-depressive psychosis can be inherited. Epilepsy is an exquisitely hereditary disease. I am not sure but that the tendency to some forms of delinquency may be inheritable.

The environment, it must be remembered, however, affects not only the ill-born, but also the well-born. At this meeting today we are more directly interested in the study of environment, (1) on the physical side, (2) on the psychic side and (3) on the social side.

On the physical side the importance of properly nourishing children, housing them, clothing them, resting them, exercising them, protecting them from infection, are all obvious to every one —to the laity as well as to physicians. On the psychic and social sides, however, people are not fully awake, I believe, to the importance of the problems that confront them, though they are becoming awakened by meetings of the kind we are now attending.

On the psychic and social sides of the development of the child, the family and the servants in the family come first into consideration. Then come, I think, the neighbors, the neighboring children especially; then the school, then the church and other associations into which the child enters. Then there are books, plays, moving-

picture shows, theatres and things of that sort to be borne in mind. I put the family first because I believe that is the most important factor, and it is in its influence that most mistakes, perhaps, are made, and in it much can be done to improve conditions.

The study of the normal family becomes ever more interesting to sociologists and to social workers. I do not know how many of you have read the recent article by Margaret F. Byington on this subject, but it is a valuable and readable paper. Any of you who haven't read it would, I feel sure, enjoy looking over it. In it she points out how in recent times the conditions of the family have changed, especially regarding the economic cooperation of the family. Formerly, every member of the family had to be cooperative in the family as an economic unit, but now the economic side is less prominent and the main characteristics of the environmental influence of the normal family are cultural, educative and disciplinary. In my own opinion the family is the chief place for the cultivation of adequate personal expression, for teaching the proper control of impulses and for favoring the growth of the higher sentiments and ideals. It is the place for the organization of the primitive instincts into higher psychic units. It is, and should be, the family in which the child becomes initiated by example, by precept and by opportunity into the social life of his time.

Now, in the family, both the mothering and the fathering are important. Let an institution do what it will, be it as good as this* is, there is something that comes from the emotional side of family life that is impossible to get in an institution where the children are not in contact with and under the influence of their fathers and mothers. This contact and this influence are not replaceable, so the family is a better place to grow up in than an institution, provided the family is a normal family. But when the family is abnormal, then it may be important, and often is very important, to transfer the child to an institution.

The habits of the child, the interests of the child and the ideals of the child, are gradually developed in the normal family. There may have to be sometimes a little physical punishment very early. In a normal family I should think that perhaps one salutary spanking was enough. I have observed instances in which one spanking during the first two years—not afterwards—was admin-

* The New York State Training School for Girls, at Hudson, New York, in which the meeting was held.

istered and seemed helpful. With a normal child, after that one spanking has been given, it is rarely necessary, provided there be consistency and good sense in the management on the part of the father and mother, to resort to further physical punishment. Rewards and punishments of other sorts, especially judicious praise and very occasionally pedagogic blame, are useful as agents to modify a child's behavior.

The child's allowance chart* is a helpful means, I believe, in making the child learn to govern itself. After a child reaches the age of six or eight it is often irksome to the parents to be saying, and hard on the child to be hearing, "Don't do so and so." In the allowance chart there is a list of twelve or fifteen things to which the child needs to pay attention; for instance, getting down to breakfast on time, having its hands washed before dinner, observing punctually the study periods, and keeping its desk in order; there are a number of little things that every mother has to make sure that the child does. In the allowance chart the child is allowed a certain number of marks for each one of these duties faithfully performed during each day. At the end of the week, if the child's allowance is 50 cents per week, and he has got only 50 per cent of the marks that are given for full performance of his tasks, he will receive only 25 cents. I have seen this tried in a number of families with remarkably good results. The children keep the chart themselves and thus learn to govern themselves. They have to be children of the better sort, perhaps, to do this, but the use of this method often relieves the father and mother of much detail of personal supervision. After a child has kept such a chart for a few months it can often be dispensed with. The children I have observed have been honest and conscientious in recording their marks.

A word as to caprices of children regarding diet. As a practitioner of medicine I have found that no small part of the troubles of patients about eating in later life, dates back to the mistakes of childhood training, when parents permitted caprice. Parents should know what is a good diet for the child, should place the food before him and should see that he eats it. Parents are often responsible by being capricious about food themselves. A parent's bad example may be very harmful to the child. Parents should set the example of eating all kinds of simple foods regardless of choice, and no child's likes and dislikes in regard to diet, except in

* Obtainable from Rowland and Ives, 225 Fifth Avenue, New York City.

rare instances of undoubted idiosyncrasy, should be very much heeded.

And now a word as to regular bathing. Many children hate to take a bath, but if the parents bathe daily themselves, and teach their children in early life to bathe daily as a regular habit, these children as they grow up look upon the daily bath as a most natural habit, and expect nothing else. The same applies to exercise and to proper dress. The child should have regular hours for exercise in the open air and the parents should make proper provisions for this and make sure that it is made enjoyable. Children should also have regular supplies of simple, sensible, clean, attractive clothing, and should be required to wear what is supplied.

The general physical and psychic hardening of children is another important matter. Many children, especially nervous children, are oversensitive. Much can be done to help by a judicious hardening process. Common sense, of course, is necessary, for it is harmful to take a child that is oversensitive and be too hard with it. Parents, especially among the well-to-do, are prone to err on the side of indulgence rather than on the side of overhardship. They are often not firm enough with children in regard to the maintenance of a normal routine, allowing their children to break through it too easily. When parents are in doubt as to the course they should pursue they should seek the advice of the family physician.

In educating the children to self-control, and especially to control of temper, parents can do a great deal. Many parents allow children to give way to emotional outbreaks. If a child cries for something hard enough the foolish parent will often give it what it wants. This is, of course, a disastrous policy to pursue. I once knew a girl in a large American city who boasted that she could make her father give her a Packard automobile just by going into a tantrum, and she did. She had found out that she could get anything she wanted if she made enough fuss about it. Rewarding emotional outbreaks in such a way is very injurious to a child. A child should be taught that it can more often secure things that it desires by controlling itself, than by losing control. It is self-control that should be rewarded, not the evidences of lack of control.

If a little child, for instance, crying because it wants something very much, be taught to stop crying, and to say, "Please, may I

have that?" before it is permitted to have it, it will learn that self-control, rather than the lack of control, has brought the reward.

Consistency in policy and attitude on the part of the parents is essential if a child is not to be misled and confused. How often one hears a mother tell a child to do something, and then observes that this mother's own attention becomes distracted, so that she allows the child to do something else, to the neglect of carrying out the order given. If in early childhood an order be once given, one should see to it not only that it is obeyed, but also that there is prompt obedience. Again, a mother should not follow one policy one day and another the next. Such inconsistency can be very harmful to the developing child. For the same reason, the father and mother should agree on the course to be followed and should make sure that they support each other in it. To develop any stability in a child one must be consistent in the demands made of it.

Then comes the example of cheerfulness and of good will. Parents who give way to their own depression before children may do them a vast deal of harm. Parents who indulge in fault finding, and who impugn the motives of others before children, set a bad example. Parents who indulge in personal gossip before their children exert an influence that may lead their children to the pernicious habit. Parents who complain of their own ills, such as their headaches, their pains and their lack of appetite, before the children, may plant the seeds of hypochondriasis in the minds of the children. A mother ought to be ashamed to admit to her child that she has a headache, for during this early period there is great danger of "psychic contagion." Much that has been attributed to heredity is really due to psychic contagion in childhood. Many people develop "habit headaches" and "habit pains," and unwillingly encourage the development, by imitation, of similar headaches or pains in their children. Everyone should learn to "consume his own smoke." We help other people to keep well if we ourselves give the impression of feeling well and cheerful. Here, if anywhere, is the place to assume a virtue if you have it not.

A child should never be permitted to use invented physical symptoms or nervous symptoms to escape from its duties. Many a child learns that he can stay home from school, or from Sunday school, or from dancing school, by having a headache. Children, as well as grown-ups, are tempted to invent some excuse

in the hope that they may escape duties or occupations that are a little unpleasant or irksome to them at the time. The wise parent should see to it when the child says he has a headache and is permitted to escape some normal function, or some duty, on account of it, that he does not have too good a time. Let him stay in bed with restricted diet, restricted companionship and restricted activities until the headache is better, and then if he has been fabricating his headaches he will not have them so often.

Good teamwork on the part of the parents is, as I have said, very important. Sometimes the father will undo all the mother does in the way of discipline, and sometimes the mother will undo all that the father has tried to do. Nevertheless, it is most desirable that the child grow up under the influence of two parents. The fatherless child is to be pitied, just as the motherless child is to be pitied. The disastrous effects of the prolonged absence of the father on the child are being seen now in Canada, in Great Britian and in France during this war. We are going to see something of it here in the United States if several hundred thousand fathers remain away for a long time. The effects upon the unhusbanded mother are bad enough; the effects upon the temporarily unfathered child are perhaps worse. We must prepare, too, to meet the problem of the permanently fatherless child in the reconstruction period.

The peculiar situation of an only child is worthy of special consideration. We know now that it is a very dangerous thing to be an only child. There are very real advantages when there are several children in a family, and the advantages are greatest when these several include both boys and girls, for boys and girls as playmates in the same family exert upon one another a beneficial, educative influence that can be obtained in no other circumstances. The only child, moreover, is likely to be too much with grown-ups and to be overindulged by them and by the parents. Contact with playmates outside, though very important for the only child, can never fully and satisfactorily replace contact with brothers and sisters in the same family.

The dangers of contact of young children with ignorant and unscrupulous servants cannot, in my opinion, be overestimated. In this country too many of the servants now accessible as children's nurses come from very low sources. Their ideals of family culture and of education are often wholly different from those of the families they enter. The children, if left much with such

servants, get too much of their education on a low social level, instead of on the social level of their parents. More and more people seem to be willing to leave the education of their little children almost wholly to certain girls of the type mentioned. This can be only a mistake. The matter should be taken much more seriously than it is at present. Fortunately, many servants and children's nurses are excellent companions for little children. Among them are many sweet-natured, conscientious and high-minded persons who exert only a good influence upon the children. Indeed, among our newly rich I have more than once met with instances in which the influence of servants and nurses was more wholesome than that emanating from the parents!

Every parent should know what children his own child plays with, who they are, from what sources they come, how long the children are together and where and how they are supervised when they are at play. The reasons are obvious.

The timely sex instruction of the child should of course come from the parents or from the school. Most of it, I think, should come from the parents. It is exceedingly desirable that one of the parents at least, preferably both of them, should retain the full confidence of the child, keeping in sympathetic communication with it as it develops, so that when curiosity regarding childbirth, parenthood or the sex relationship arises in the child's mind the child will go to one or the other parent and have its curiosity satisfied by an explanation that is a true one, but suited to the age of the child at the time. Good judgment is necessary in deciding how far to go in explaining such things to children, but if the child's curiosity, when it has been aroused, be sufficiently satisfied with simple, suitable, honest statements by some one in whom it has confidence, all sorts of grave difficulties may be avoided. I would re-emphasize the fact that a sympathetic relationship between the children and the parents is essential. Many children who become erratic and delinquent do so because they did not have any one in whom they could at certain important times properly confide. Fathers and mothers too often fail to realize the importance of this. They should try to recall their own perplexities of childhood, when they wanted to know things about which they dared not ask their fathers or their mothers. The relationship between the child and its parents should, if possible, be so maintained that the child will ask spontaneously for information on the subjects under discussion, without any conscious

effort on the part of the mother and father to influence it to do so. Confidential inquiries of that sort, if sympathetically and wisely responded to by parents, would save the children in many instances from injurious misinformation and sometimes from serious trouble. Children thus parented would not need surreptitiously to seek sex instruction from boys and girls in the neighborhood with whom they happen to be thrown in contact, or from servants. Moreover, if such children, as is often unavoidable, imbibe untimely or erroneous sex information from the extra-familial environment, they would take this at once to their parents, by whom any false ideas could be quickly corrected and through whom avoidance of undesirable contact would be arranged.

Another difficulty in the rearing of children that ought to be emphasized, I believe, is the overattachment that sometimes is permitted to develop between fathers and their daughters, and between mothers and their sons. The child's need of affection can, and should be, reasonably gratified by parents without exposing it to the dangers of overtenderness and without, as it grows older, protecting it so completely from the rough places of the world that it shrinks from facing the realities of life and tends to nestle snugly in an infantile paradise. Abnormal attachments between children and their parents are by no means uncommon. The psychoanalysts have laid a great deal of emphasis on these pathological relationships, and I think the subject should be ventilated. Whereas, normally, there should be deep and genuine affection mutually felt and exhibited, great care should be taken that it does not exceed normal limits and interfere with the later life of the child. There should be no cultivation of, or indulgence in, overfondness and overaffection, especially between mothers and sons, and fathers and daughters, for very often a fixation of the affections on the parent occurs that prevents the normal emancipation of adulthood. One of the things that parents must willingly learn to do is to consent to the setting of their children gradually free from themselves. The time comes for every developing personality when it should be released by its parents from all legal, social, intellectual and moral restraints, when, in homely words, the tub is not only permitted, but is required, to stand on its own bottom.

It is highly desirable that the affection of children for their parents should be strong and close in early childhood, at the time when the authority of the parents over the children is supreme,

but the child should be gladly and relatively quickly taught by the parents to spread its affections over others in and outside the family, and should be shown how gradually to gain its independence from both the father and mother. A boy should never be tied too long to his mother's apron strings, and a girl should never be so fond of her father that she cannot fall in love with the proper man and go with him to live when the proper time for this comes. Many lives are being ruined, in my opinion, every day by this overfixation of affection—this overattachment of older children and adults to their parents. Surely none will misunderstand me here. I am not praising Goneril and Regan, and I admire Cordelia, whose love for her father was richer than her tongue, but even she left her father to marry a worthy husband.

A father should be careful not to carry his authority over a boy too long or make his rule of his boy too rigid, or the boy may develop a hatred for his father that may lead to all sorts of difficulties with father-substitutes later on. Thus, the boy may later transfer the hatred of his father to his teacher, or to any other father-substitute with whom he comes in contact, either in boyhood or in society in later life. It is believed by psychoanalysts that the world's quota of anarchists and fiercer revolutionists is largely contributed to by father-haters, that, indeed, their manifestations are in reality merely disguises of father-enmity. However this may be it would seem certain that much harm can come from overrigid treatment of a boy by his father. The father's full authority should be exerted only in very early childhood, when it is necessary to teach the boy to control the primitive impulses as the sentiments are being gradually developed by example, by precept and by contact with the social environment. The father and mother should not try to keep such full control of their children long, and they should face the prospect of giving up all control after a certain time. And at no time should more compulsion of children be resorted to than is absolutely necessary for the formation of normal, healthy habits.

A child should never be made to feel inferior, for a feeling of inferiority may do a vast deal of harm. Even if a child be subnormal, it is important to try to protect it from feelings of inferiority. Thus, if possible, a subnormal child should be kept from coming into conscious competition with normal children. When a physical defect of any kind is present, for example, a residual shortening of a leg from poliomyelitis, a facial paralysis or a spinal

curvature, an effort to convince the child of the possibility of counterbalancing advantages should be made.

I have heard of a mother who always spoke of her little girl as an "ugly duckling." The child was not particularly handsome, but she was a good and attractive child. The mother, for some reason, was ashamed of that child, and gave expression to her shame always in front of other people. She would say, "There is my ugly duckling; what shall we ever do with her?" Sometimes she would remark, "She will never marry—that ugly duckling." Think of the discouraging influence of such comments upon the child!

During adolescence the child should be encouraged to face the real situations of life when confronted with them, and should be kept from turning away from them, or denying their existence, or finding sufficient satisfaction in the wish-fulfillments of daydreaming and phantasms. The so-called "autistic-thinking," which avoids reality and which indulges in pleasurable emotional states at the expense of wholesome objective activity is to be recognized when it exists, and any excess of it is to be combated, not directly by the prohibition of the pleasure-seeking automatism, but rather indirectly by sympathetic guidance in the processes of "reality-thinking" and by the encouragement of objective activities that compel plungings in the cold waters of actuality, that force swimming to avoid sinking, thus educating to self-reliance.

The problem of avoiding the spoiling of the child is, then, a large one. It involves biological, medical, psychological and social considerations. Heredity and environment are equally important. In the latter, along with strength of body, the chief stress is to be laid upon adequate provision for the organization of the mental life. Instinctive tendencies must have proper opportunity for expression; there must be education to sufficient self-control; attention must be given to the growth of the sentiments; the child must have opportunities to live out its fundamental traits, while at the same time it is subjected to the influences of the social surroundings and the ideals that will lead to the higher planes of conduct; and, finally, it must secure full emancipation from family, teachers and even friends, gnawing with its teeth, if necessary, its bonds asunder to gain its freedom. When we can see our way clear to such provisions we shall learn how to avoid "spoiling the child."

MENTAL DISEASES IN NEW YORK STATE DURING THE WAR PERIOD

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THE influence of the war in causing mental disease among our civilian population can never be definitely known. Our hospital records give a complete account of the disorders of the first admissions during the four years of the war, and we may compare the results during these years with those of preceding years; but when this is done we cannot be certain that changes in results are due to the war. It is but reasonable to suppose, however, that the war by increasing excitement, anxiety and grief has been a precipitating factor of no small importance in the causation of mental disease.

The available facts that have a bearing on the question may be set forth under the following heads:

I. Increase of insane patients in institutions.
II. Increase in first admissions.
III. Changes in the principal clinical groups.

I. INCREASE OF INSANE IN INSTITUTIONS

The statistics of the institutions for the insane in New York State are compiled by fiscal years. Prior to 1916 the fiscal year ended on September 30; since that time it has ended on June 30.

The yearly net increase in patients in all the institutions for the insane in the state since 1911 has been as follows:

Fiscal year	*Net increase*
1911	653
1912	662
1913	1,060
1914	691
1915	939
1916 (9 mos.)	918
1917	1,183
1918	937

The net increase in patients during the four years preceding the war was 3,066, or a yearly average of 767; the net increase during the 3¾ years following the outbreak of the war was 3,977, or a yearly average of 1,061. The difference between the increases in

the two periods is quite remarkable, but it is accounted for in part at least by the accumulation in the hospitals of deportable aliens who could not be taken to their homes in Europe while the war was in progress.

Additional light is thrown on the subject by the following tabulation showing the ratio of patients under treatment to the general population of the state from 1908 to 1918.

Insane Patients in All Institutions at End of Fiscal Year

Year	*Number*	*Per 100,000 of general population of the state*
1908	30,457	349.6
1909	31,540	352.9
1910	32,658	358.3
1911	33,311	361.0
1912	33,973	363.6
1913	35,033	370.4
1914	35,724	373.2
1915	36,663	378.4
1916	37,581	383.4
1917	38,764	391.9
1918	39,701	395.7

It is seen that the rate per 100,000 increased 11.4 points from 1908 to 1911; 12.2 points from 1911 to 1914; and 22.5 from 1914 to 1918. The rates are based on the federal census of 1910 and the state census of 1915 and estimates made therefrom for the other years. As immigration has been greatly reduced by the war and as many men have been removed from the state for military purposes, it is probable that the estimates of population for 1917 and 1918 computed according to standard methods are too high. If this be true, the ratios of the insane to the general population for these years as given above are correspondingly low.

II. INCREASE OF FIRST ADMISSIONS

As the hospital population comprises many cases of long standing as well as recent admissions, it is believed that the first admissions form a better index of the rate of insanity during any given period.

In New York State first admissions have been carefully distinguished from readmissions since the beginning of the fiscal year of 1909. We are therefore able to compare the rate of first admissions during the war period with that of the years immediately preceding the war.

First Admissions to All Institutions for the Insane in New York State, 1909–1918

Year	Number	Rate per 100,000 of general population of the state
1909	5,784	66.4
1910	5,944	65.2
1911	6,228	67.5
1912	6,300	67.4
1913	6,650	70.3
1914	6,789	70.9
1915	6,690	69.1
1916 (9 mos.)	5,269	53.8
1917	7,340	74.0
1918	7,244	72.2

The average annual rate for the 4 years 1911 to 1914 was 69.0 and for the $3\frac{3}{4}$ years from 1915 to 1918, 71.7. For the reasons stated above, it is probable that the rates given for 1917 and 1918 are too low, but we shall have no basis for their correction until the data of the 1920 census are available.

III. CHANGES IN THE PRINCIPAL CLINICAL GROUPS

A closer view of mental disease in the state during the war period may be obtained by examination of the changes that have occurred during the past 10 years in first admissions with principal psychoses. For this purpose we take only the first admissions to the civil state hospitals and select the senile, paretic, alcoholic, manic-depressive, involution melancholia, dementia praecox and psychoneurotic groups. Together these constitute about 70 per cent of all first admissions.

First Admissions with Certain Psychoses, Civil State Hospitals, 1909 to 1918

Year	Senile	General paralysis	Alcoholic	Manic-depressive and allied forms	Involution melancholia	Dementia praecox and allied forms	Psychoneuroses
1909	606	658	561	574	207	1181	44
1910	615	815	581	769	143	1015	61
1911	583	758	580	826	143	1031	66
1912	596	719	567	854	119	1129	74
1913	594	768	572	924	133	1250	105
1914	542	774	464	880	188	1445	106
1915	570	814	345	879	165	1663	73
1916*	486	640	297	846	164	1173	57
1917	585	866	594	1136	201	1786	77
1918	652	913	354	976	219	1883	83

*9 months.

Computing the average annual admissions for the 4 years 1911 to 1914 and for the 3¾ years 1915 to 1918, we have the following results:

	Average annual admissions 1911–1914	*Average annual admissions 1915–1918*	*Per cent of increase or decrease*
Senile	579	611	5.5
General paralysis	755	862	14.2
Alcoholic	546	424	22.3*
Manic-depressive and allied forms	871	1023	17.5
Involution melancholia	145	200	37.9
Dementia praecox and allied forms	1214	1735	42.9
Psychoneuroses	88	77	12.5*

Referring to the foregoing figures we note a slight increase in senile cases and a more marked increase in cases with general paralysis. The etiology in these groups is well known and it is probable that the war is not responsible for the increase to any great extent.

In the alcoholic psychoses the decrease in cases may have been influenced by the restrictions placed on the liquor traffic during the war, but a marked decline in the influence of alcohol in causing insanity was noted the year before the outbreak of the war. The reasons for the rise in the number of cases in this group in 1917 and for the sudden drop again in 1918 are not known.

In the manic-depressive, involution melancholia and dementia praecox groups the increase in the annual number of admissions during the war period is quite striking. In dementia praecox especially the change has been remarkable. Part of this increase may be due to modifications in diagnostic principles, but in the main the figures may be taken at their face value.

The influence of the war in bringing the constitutional cases of mental disorder into the hospitals is a matter of conjecture. It seems but reasonable to ascribe a part of the increase in the annual admissions in these groups to the mental conflicts arising from circumstances connected with the great war. Social and economic changes produced by the war may also have a bearing on the matter.

The annual rate of first admissions of the psychoneurotic group decreased during the war period. However, as this group is so

* Decrease.

small and is subject to such marked variations no significance can be attached to the change during the war period.

The full effects of the war have not yet reached the state hospitals. The influences thus far felt are not those of actual army service, but rather the secondary currents that have reached the civilian population. Most of the soldiers who became insane in active service are being cared for in army hospitals. Many of those who recover from the first attack and are discharged are likely to appear later in our hospitals as readmissions. It is also probable that there are a large number of soldiers, who have suffered severe mental strain during the war, that will be unable to make the adaptations necessary to success in civil life. Some of these will ultimately need treatment in the state hospitals.

CONCLUSIONS

1. It can be reasonably inferred that the war has been a precipitating factor in the causation of some forms of mental disease among the civilian population.

2. The number of patients under treatment in institutions in the state increased more rapidly during the war period than during the four years preceding the war. The increase was due in part to the accumulation in the hospitals of deportable aliens.

3. The ratio of first admissions to the general population of the state increased during the war period.

4. The rate of alcoholic insanity decreased during the war, especially in the years 1915 and 1918.

5. Marked increases occurred during the war period in first admissions in the manic-depressive, involution melancholia and dementia praecox groups.

6. It is probable that further increases in the rate of mental disease will occur following the return and demobilization of the army.

MENTAL TESTS*

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AS long as there has been even the slightest amount of organized social life, so long have men sized up their fellow men. In meeting another in business, in professional, or in sociable intercourse, a man makes a judgment as to what characteristics that other individual has, and what sorts of things he is capable of doing. This judgment is based on the reports of others, on the other's method of conducting business, or on his manner of meeting people. A special tone of voice, the manner of address, interruptions in conversation, and comments on friends and acquaintances, are often the basis of a marked prejudice for or against an individual, in other words of a judgment regarding the capabilities and the characteristics of the person. It is at best but inspection with a certain modicum of logical considerations that make up this casual judgment. But in this casual judgment we find the nucleus of the more systematic and scientific method of grading intelligence which has become prominent in the past few years.

Besides the simple method of inspection, resulting in the casual judgment, other methods came into vogue. It was appreciated that a man might look like a fool, but be capable and even brilliant in a certain line of endeavor, and that a man might look perfectly normal and very capable, but actually be a fool. Heredity was used as a basis of judgment. "Like father, like son," was the saying. Certain families were supposedly distinguished from others by the possession or lack of certain characteristics. The son of a good boot-maker was thought to be capable of becoming a good boot-maker, the son of a capable farmer was thought to be capable of becoming a farmer, and so on throughout the various trades and professions. This simple method of making judgments had a firmer basis of extended observation, as we now look at the matter in accordance with our present scientific knowledge. Nowadays we put the matter in slightly

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different terms. We say the boy living in a certain environment has acquired certain habits (or conditioned reflexes) which enable him to react appropriately under certain conditions of stimulation. Thus, the child of a boot-maker has the opportunity to form certain habits in relation to leather and its workings, to the grades of material, to the use of different implements, to complaints about boots, etc. These habits are, it is understood, important in the manufacture of boots. In so far, therefore, as habits are indications of intelligence this method is important, but it is also too unsystematic. It takes into account only the special environment; it but takes the obvious and fixes this with too much meaning and significance.

This method of judgment from heredity and partial environment does not coincide any too accurately with the individual's capabilities and his characteristics. Not infrequently it happened that the warrior's son was too peace-loving, and the shoemaker's boy sometimes became a poet. How, then, can one determine the child's or the man's capabilities better than by the method of casual inspection and better than by the method of heredity? Can this be done for a special occupation, such as that of a priest, or can this be done only for general intelligence? The need for a better method was appreciated, and different suggestions have been made. Only one of these historical methods need detain us here. The most noteworthy of the attempts was that of Gall and his partner, Spurzheim. Starting with the assumption that the brain is the all important determiner of action, but with a grossly inadequate knowledge of this organ, the proposition was set forth that bumps on the outside of the head show the conditions within, and that these bumps can be "read" in terms of talents or aptitudes, of inclinations and of other special characteristics. The vogue that phrenology had with those who had any pretense to psychological or other scientific training and knowledge has passed, because it also was a very indirect method of determination. Unfortunately, however, there are still those who "read bumps," just as there are those who depend upon the lines of the hand to determine future successes as well as past performances, and those who think they are able by examining a specimen of handwriting to detect characters of persons unknown in other ways. One might equally well judge another's wealth by the kind of clothes he wears, his knowledge by the number of books in his library, and his habits of thought

by noting how he has his hair brushed. It is more to the point to know whether or not the person pays his tailor, whether or not his library is a legacy, and whether or not his wife insists on having his hair brushed in a certain fashion.

All of the methods of estimating intelligence which have been mentioned considered parts of the personality which have relation to intelligence, but which do not measure intelligence. Since the object of tests or the selection of criteria was for the purpose of determining mental things, it should have been obvious that the tests should involve not the clothes one wears nor the way one brushes his hair, but what one knows and how readily one can acquire new mental things, make new adjustments, and use what one knows. These matters are given weight in the more recent scientific testing of intelligence. It is clear, however, that to determine the relative intelligence of an individual, we should find out how many things he knows, how readily he learns new things. These facts must be correlated with the environment—*i. e.*, the opportunities the person has for learning—and with his age. In addition, it is essential that the person be judged in relation to others of the same environment. But even though this process of examination or testing were possible, it would be impracticable. It would be necessary to examine a person in every possible way. This would take days, or even months and years. How to make tests that fairly accurate estimates can be made, and at the same time not take too long and thus involve too great labor and expense, is much the same as in every science. From a large bar of steel the chemist takes a few small samples, determines the composition of these and bases his judgment of the whole bar by making comparisons of the samples with each other and by averaging the determinations as indications of the "general" composition of the whole bar. So also, the metallurgist takes samples from different parts of a mine, and reports on the average of gold per ton of ore, and also may report the occurrence of more per ton in one place than in another. It remained for Binet, a psychologist, and Simon, a physician, to make these matters plain for mental testing. The investigations conducted by Binet and Simon enabled them to say that normal children of a certain age and a certain environment normally knew certain things. In other words, if a child could be "sampled," it would be possible to make a few simple tests like those of the chemist and thus determine the "mental age" or the intelligence of that child.

Thus it became apparent that a mental test having for its object the determination of general intelligence or mental capacity, should determine the character and the amount of an individual's knowledge. This is to be done in much the same way as in other testing, by taking samples or by making a cross section and using it as a basis of judgment. The ideal method of making a test for intelligence rating would be to have one test, or question, which could be put and receive one answer, and by the character and the completeness of that answer to make a suitable judgment. But because persons differ widely in many ways, many questions (tests) dealing with these matters of difference must be used, and the responses to all tests form the basis of judgment.

The original Binet-Simon group of tests has since been largely modified, some tests have been discarded, other tests have been introduced. The method of scoring (*i. e.*, in comparison with the task of the chemist, the method of analysis, upon which a final judgment is made) has also been altered. Lately other groups of tests have been devised and applied. All of these determine knowledge or lack of knowledge. In many groups of tests, and this applies also to individual tests, there is a limitation in that largely on the ability of the subject to use language hinges the grade to be given. This is a potent adverse criticism of the whole procedure of tests which are based upon or which resemble the original Binet-Simon group. If an individual uses language well, his mark, or grade, is correspondingly high, and vice versa. In short, mere verbosity may sometimes pass, in testing as in ordinary life, for native intelligence. Then there is the condition of nervousness, whether shyness or embarrassment, which prevents many a person showing at his best. Because of this there has been introduced a newer method of testing which involves language to only a slight extent.

The tests of Binet and Simon determined as far as they could the mental level of normal children of a certain environment, and were then applied to children of all sorts and conditions—feeble-minded children, inmates of corrective institutions, children of the slums, and children of wealthy parents—and it was found that the tests do in general determine a kind of mental level. Recently testing has been extended in different directions to determine the mental level of adults, and these extensions of the original Binet-Simon tests are of special interest to the psy-

chiatrist. The widest application of tests to adults has been in connection with the mental examination and classification of recruits for the army. More than a million men were tested and the results of these tests, when they are published, should furnish valuable comparative data for the determination of normality and abnormality which is one of the chief functions of the psychiatrist. The army tests rely less on the language ability of the subject, but many of them do require that the subject shall be able to read, be able to understand what is said, and carry out the orders which are given.

Another kind of test appears to have wide application, the outcome of practical tests which have been used for years. A manufacturer hiring a machinist may determine his competency by finding out, if the applicant tells the truth, what kinds of positions he has previously held, or he may determine it in a very practical way by getting the applicant for a job to show his ability at a lathe or other machine to which he may be assigned. Or the builder hires a bricklayer, and pays him while his competency is being determined. Such practical tests are, however, expensive. They risk costly machinery and materials, and if an unskilled man be permitted to try to do work for which he has no competency he may endanger the lives of others as well as his own. Tests have been devised so that the ability of a machinist, for example, may be determined without the danger of loss of material, destruction of tools, and the payment of wages. Other occupational tests have also been devised to test the fitness of applicants for other kinds of work, and in some cases it is possible by means of tests to determine the relative skill of an applicant, whether he be novice, apprentice, journeyman, or expert. Many of these tests are of the character known as "performance" tests, and are relatively independent of language ability. Some are entirely independent of language ability, either of expression or of understanding, except in so far as gesture is a part or a kind of language.

In making tests of mental intelligence it is necessary (1) that questions or problems be presented which are known to be answerable or soluble, and (2) that data be available on many individuals of known intelligence or skill to determine at what level of intelligence or skill each question is likely to be answered, or each problem solved, in whole or in part or rightly or wrongly. The lack of appreciation of the latter point is apparent in some

of the work that followed the publication of the Binet-Simon series of tests. For example, these tests which were devised for children have been applied to senile dements, to general paralytics, and to other abnormal cases to determine their "mental ages" in comparison with children. With equal right, because of the occurrence of the Babinski phenomenon in the infant and in the adult hemiplegic, one might infer that the hemiplegic's nervous system is like that of the infant. If, therefore, tests are to be used for diagnosis, whether of mental age or any other condition, it is necessary to have data on normal people of the same age and of the same social status. It is not sufficient to say: "I know this, and any one who does not know it is abnormal." Norms must be established.

In the case of children this problem is simple enough, for the different grades of school furnish such a standard of intelligence, and thus it is possible to determine the reactions of children at different levels of school life. But it is not so with adults. Here the examiner must often rely on the known or the reported success or failure of the individual under examination, or on his capacity or inability to learn as shown in his relations to others, and the test must, therefore, be standardized with these extraneous facts. The examiner must get data on the characteristics of the individuals to be tested by the tests he selects. Are the people successful in business? Could a laborer, or an artisan, or a professor answer these questions or solve the problems which are presented? By testing the tests one can eliminate those tests which apply to only one or two groups of individuals. Or one may, if it is desirable as in the case of trade or occupation testing, devise special tests to fit special conditions. At the same time one may also devise and standardize tests which will quickly divide large groups into smaller groups, such as the poorly educated who are not able to solve a certain set of problems, but who can solve another set that cannot be solved by those with no education.

There is yet another element to be considered in making tests or determinations of mental level—the speed of performance. It is important to know not only "Can he do this?" but also "Can he do twice as much as another?" One who knows twice as much as another, who can adapt himself in one half of the time, or who can perform twice as much intellectual labor in a given time, is more intelligent than the other individual. In the army

testing scheme this consideration was taken into account and it enabled the examiners to determine different degrees of knowledge or intelligence. For example, it was not only a matter of whether or not a man knew that $12 \times 16 = 192$, but it was also a matter of how rapidly he could demonstrate his knowledge. In other words, accuracy of thinking is combined with quickness of thinking in the most intelligent, and the two factors—accuracy and speed—must be duly considered in making any proper estimate of mental ability.

In the early days of the utilitarian tests it was believed, and unfortunately is still believed in some quarters, to be too great a refinement to carry out the tests with complete accuracy. Such a test is, though, only a kind of sampling. It is rather like a chemical test, in which it is well recognized that comparable results are not secured if one tester uses diluted sulphuric acid, and another uses concentrated acid, or if one uses water as a solvent and another uses alcohol for this purpose. It should be unnecessary to say that it is essential that the same processes be established in the application of mental tests of a certain character. Only in this way can we expect to have results that are comparable. Let us consider a concrete instance. A child is asked, "What color is a two-cent stamp?" A direct answer to this question permits the child to report any color name. But ask the child, "Is a two-cent stamp red?" and he has but two possibilities—"Yes" and "No." Or ask, "Is a two-cent stamp red or green?" and there are only two possibilities directly given, with the third possibility that a negative answer will be given. So it is with other tests. Varying methods may be expected to give varying results.

It is in the interpretation of the tests that one of the main difficulties lies. As tests are mental samplings, so the investigator must consider the results of his samplings as the prospector and the metallurgist consider their ore. One point that must be noted is that a child or adult be not judged too harshly on the result of one test. It may be that the mental mine has been sampled at a point where relatively poor ore is to be found. If the whole is to be judged, more than one sample should be taken for test. Thus the rural child is of far different environment from the city child, and should not be expected to test in the same manner. When we deal with adults we must bear in mind that their environments—business, professional, educational, social,

and what not—have been much more varied than those of children who have been compelled to go to school. Children because they have had the school environment are to be expected to test more nearly alike than adults who in many ways have been changed by their environments—by the daily press and magazines, by mail order catalogues, and the like.

DRUNKENNESS AS SEEN AMONG WOMEN IN COURT

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ONE of the commonest charges against women offenders in court is drunkenness. How widespread is its prevalence; how serious are its many ramifications into the social life of the community, it is not the purpose of this article to discuss. But this group of individuals presents, in common with other types of delinquents, certain medical features that may be very well worth considering. We hope that such a study may throw some light on this particular aspect of the problem. The data presented for discussion were obtained from the records of the last 100 cases of drunkenness among women referred to the medical service of the Municipal Court of Boston.

In four fifths of the cases there was a special query concerning the individual's "physical fitness for employment." In other words, in the majority of all cases referred, this was the idea that was uppermost in the mind of the probation officer. It is evident that in questioning their "physical fitness" the probation officer did not mean to imply that she had selected these eighty persons because they were suffering from some well-marked physical disease, for careful examination showed that 71 of them were in good or fair physical condition. But the intelligent probation officer, having continually in mind the serious handicap that physical disease may prove to industrial efficiency and the danger of venereal disease to the general public as well as to the individual, as a matter of course seeks information on these points wherever possible prior to securing employment for the individual.

Evidently the great majority of these 100 cases were considered fit by the court for supervision on probation, for 64 had had their cases already disposed of, and had been placed on probation prior to being referred for examination.

It is the purpose of this paper to present certain medical facts that would appear to be intimately related to the data the court had in its possession at the time of the disposition of the several cases. It is hoped that these facts will throw some light on the

cases under consideration. Before doing this we should like to present a few tables, showing the ages, living conditions, marital status, employment history, alcoholic habits, frequency of offense, disposition, etc., of the 100 cases of drunken women whom we are considering.

Table 1.—Ages

Under 20 years	1
21–30 "	31
31–40 "	43
41–50 "	16
51–60 "	6
61 years or over	3
	100

A great majority of these persons—74 per cent—were young adults, ranging from 21 to 40 years.

Table 2.—Living Conditions

At home	46
Rented room	42
No address	12
	100

Forty-six per cent of these 100 women lived at home; 42 per cent in rented rooms; while 12 per cent were "floaters," having no address.

Table 3.—Marital Status

Single	26
Married	32
Widowed	14
Divorced	2
Separated	25
Married (husband in service)	1
	100

Of these 100 cases 26 had never married; 74 had been married, but only 32 were living at home with husbands.

Table 4.—Employment History

Regularly employed	11
Irregularly employed (frequent changes)	30
Odd jobs	14
No work	16
Housework at home	29
	100

Only 11 out of the 100 cases had been steadily employed; 30 worked irregularly, changing positions frequently; 30 either never worked at all or simply did odd jobs; while 29 did their own housework at home.

Table 5.—Alcoholic Habits

Occasional	26
Periodic	48
Steady	26
	100

In only 26 of the cases were we dealing with persons who had not formed well-marked alcoholic habits, 74 of these individuals having become habitually accustomed to its use. Two were also drug users.

Table 6.—Frequency of Offense

1st Arrest	31
2nd Arrest	12
3rd Arrest	12
Recidivist	45
	100

While 69 had been in court before, the majority of these cases would, from the point of view of their court records, still be considered mild offenders. It might be mentioned that in addition to arrests for drunkenness, these 100 offenders were arrested 29 times for offenses against chastity; 6 times for larceny; once for violating the drug law; 3 times as "stubborn child"; and once for assault and battery.

The treatment meted out by the court to these individuals is shown in the following table:

Table 7.—Court Treatment

	1st Arrest	*2nd Arrest*	*3rd Arrest*	*Recidivist*
Cases under consideration	31	12	12	45
Released by probation officer	..	8	13	127
On file	..	..	4	124
Probation number of times given	31	15	17	145
Broken	..	1	5	87
Inside probation	..	2	1	23
Now on probation	31	10	9	21
Dismissed	..	2	2	14
Penal treatment:				
Fixed time	..	..	3 mos.	142 mos.
Indeterminate sentences	..	1	..	54
Dismissed by court	..	..	..	1

There were 31 first offenders, each one was given probation, and at the time of examination was on probation. There were twelve second offenders; these individuals had been released eight times by the probation officer without bringing them to court. In 16 instances they were brought to court, placed on probation in 15 cases, and once given an indeterminate sentence. While on probation one had to be surrendered to the court; two were placed on inside probation, that is, confined to the House of the Good Shepherd or the Welcome House. Two were dismissed.

There were 12 third offenders, totaling 36 arrests. In 13 instances they were released by the probation officer without bringing them to court. In 23 instances they were brought to court; their cases were put on file 4 times; they were placed on probation 17 times, and sentenced twice. While on probation, five had to be surrendered to the court, and one placed on inside probation; two probationers were dismissed as successful, and nine were on probation at the time of examination.

The 45 recidivists were released 127 times by the probation officer without bringing them to court, they were rearrested, brought to court and their cases put on file 124 times; they were again rearrested, brought to court and placed on probation 145 times; 87 times they broke their probation and had to be surrendered to the court; they were placed on inside probation 23 times; their probation was dismissed as successful 14 times; while 21 are at the time of this writing on probation. The court in addition had tried out penal treatment with these individuals, and had sentenced them in fixed time to 142 months of imprisonment; and in addition had given them 54 indeterminate sentences either at the State Farm or the Reformatory for Women. One was dismissed by the court.

If the purpose in view has been a therapeutic one, if the aim has been by the application of such treatment to prevent further recurrences of alcoholism, we are compelled to admit that some of these cases have not responded properly to treatment. But a careful study of these individuals themselves will show in the first place, that we are dealing with abnormal material; and secondly, that our recidivist group is composed for the most part of individuals suffering from pathological conditions, who because of such handicaps cannot be expected to adapt themselves as satisfactorily as normal persons to the usual methods of treatment employed by the court.

Seen from the viewpoint of personality, we are dealing in the majority of cases with persons who possess abnormal mental traits and characteristics sufficiently well marked to influence their behavior strongly.

Table 8.—Relationship of Personality to Frequency of Offense

	1st Offender	*2nd Offender*	*3rd Offender*	*Recidivist*	*Total*
Egocentric.....	10	2	4	16	32
Emotional.....	12	7	5	27	51
No difficulties.....	9	3	3	2	17
Total.....	31	12	12	45	100

Eighty-three were more or less abnormal personalities, in some cases certain dominant characteristics being present which tended to be very harmful to the personality itself, while in other instances there were traits indicating disregard for the rights of others which made future conflicts seem probable. Thirty-two persons were placed in the egocentric group. They were selfish, egoistic, unappreciative and inconsiderate of the rights of others, unwilling to accept authority or to be guided by advice; they were suspicious, stubborn, superficial and often very indolent. Fifty-one were placed in the emotional group. They were unstable, impulsive and easily discouraged, very sensitive, excitable and quick tempered. This type of individual goes to pieces in emergencies; as long as things go well in their environment the adjustment may be adequate, but upon the occurrence of difficulties they seek to avoid facing reality, either through forgetfulness in alcohol or through some other equally unfortunate method of avoiding the situation. The periodic drinker was found common in this group. Seventeen women showed no serious personality difficulties. There were 55 persons in the group who had been arrested once, twice or three times; 15 of these or 27.3 per cent showed no evidence of personality difficulties. There were 45 who had been arrested over and over again, and were placed in the recidivist group; of these cases, only two or 4.4 per cent showed no well-marked personality difficulties.

Table 9.—Relationship of Mental Defect and Disorder to Frequency of Offense

	1st Offender	*2nd Offender*	*3rd Offender*	*Recidivist*	*Total*
Normal	7	1	1	2	11
Dull Normal	13	1	1	6	21
Epilepsy	2	1	3	2	8
Psychopathic personality	..	2	1	7	10
Feeblemindedness	4	4	4	20	32
Psychosis	4	3	..	4	11
Alcoholic deterioration	1	..	2	4	7
Total	31	12	12	45	100

Sixty-eight of these individuals were clearly distinguishable as abnormal mental types, of whom 32 were feebleminded. One out of every nine persons was psychotic and was suffering from an active mental disturbance, usually alcoholic in origin. Of the first, second, and third offenders, 56.4 per cent showed some form of mental defect or disorder; 82.2 per cent of the recidivists showed such mental handicap.

We must remember in this connection that drunkenness in women does not present the same features as in men. Not only is it less common, but addiction to alcohol with them means a further step downward than it does with men. As a consequence we should expect to find among women taken up from the streets and from cafés because of drunkenness, a larger percentage of mental defect and disorder. This expectation has been fully met in all our work, for mental inferiority is more common among women arrested for drunkenness than among men. The definite relationship between mental defect and disorder and the frequency of offense is well borne out in the study of this group, as it has been in all other types of offenders that we have investigated.

It is not enough, however, merely to call attention to this relationship. We may well emphasize the fact that reconstructive measures designed to prevent further delinquency and to rehabilitate the delinquent, if not based upon a thoroughgoing knowledge of the delinquent himself, his abilities and disabilities, promise little in the way of real and lasting success.

Table 10.—Relationship of Physical Condition to Employment

	Regularly employed	*Irregularly employed*	*Odd jobs*	*No work*	*Housework at home*	*Total*
Good.....	7	5	..	1	1	14
Fair.....	4	22	7	6	18	57
Poor.....	..	3	7	8	8	26
Bad.....	..	..	..	1	2	3
Total..	11	30	14	16	29	100

From the above table we see that 71 of these cases were in good or fair physical condition; while 29 were in poor or bad physical condition and in need of medical treatment. Eleven persons were regularly employed, all of whom were in good or fair physical condition. Forty-one were self-supporting, 38 or 92.6 per cent of whom were in good or fair physical condition. Of the seventy-one persons found to be in good or fair physical condition 38 or 53.3 per cent were self-supporting. Twenty-nine persons were in poor or bad physical condition, only 10.3 per cent of them being self-supporting. In this particular group the chances for being self-supporting were four times as good among those in good or fair physical condition, as it was among those in poor or bad physical condition.

The relationship that venereal disease bears to this problem of drunkenness, it seemed to us, was of sufficient importance to justify special study. The following table we feel is a conservative estimate, as only cases were included that had positive Wassermann reactions and in whom gonococci were found, although the well-known interference of alcohol with the Wassermann reaction must have caused us to exclude many cases of syphilis. The bacteriological and Wassermann work in these cases was done in the laboratory of the Boston City Health Department.

Table 11.—Relationship of Venereal Disease to Offense

	Drunkenness only	*Drunkenness and other offenses than against chastity*	*Drunkenness and offense against chastity*	*Total*
Syphilis.....	13	1	10	24
Gonorrhea.....	11	1	2	14
Combined syphilis and gonorrhea.....	3	..	1	4
Doubtful blood.....	2	..	..	2
Doubtful smear.....	2	..	..	2
Blood not taken.....	10	2	4	16
Smear not taken.....	10	2	4	16

Only 84 persons had blood and smears taken; 40.5 per cent of these were positive—34 persons out of the 84 examined for venereal disease were found to be suffering from syphilis or gonorrhea, or both. It will be seen from the above table that these diseases are not limited to those with a history and record for offending against chastity. Sixty-nine persons had been arrested for drunkenness only, and there was no evidence presented to the court that they had been immoral; and yet 36.6 per cent were found suffering from syphilis or gonorrhea or both.

Venereal disease has long been considered in the popular mind as purely a moral problem—a condition to be found only among prostitutes, and contracted through sexual relations alone. Such is undoubtedly the principal source of infection; but syphilis and gonorrhea are also contagious diseases and are subject to the same laws as govern such conditions in general. They may, and sometimes do, affect wholly innocent persons. We do not pretend to say how many of these cases in question were innocent infections, but we were impressed with the fact that even in those suffering from venereal disease, drunkenness, and not sexual irregularities, was the outstanding problem.

The following facts are interesting in the study of these 100 women:

Sixty-four persons—almost two thirds of these cases—had been placed on probation prior to examination; 69 as shown by a study of the record cards, had been in court before, and 45 had been arrested repeatedly, were old offenders, and had not profited well by the usual court treatment.

In 83 of the cases, we were dealing with abnormal personalities —individuals who possessed certain mental traits and characteristics sufficiently well marked to have strongly influenced their behavior along abnormal lines.

Sixty-eight of these persons were suffering from pathological mental conditions, feeblemindedness ranking highest—32 cases.

Of first, second and third offenders, 56.4 per cent showed some form of mental defect or disorder.

Of the recidivists 82.2 per cent showed mental handicaps of one form or another.

Twenty-nine persons were in poor or bad physical condition.

A definite relationship was noted between the physical condition of these persons and their ability to support themselves, in that the chances for being self-supporting were four times as good

among those in good or fair physical condition as it was among those in poor or bad physical condition.

Of the 84 cases having blood and smear tests made, 40.5 per cent were found to be suffering from venereal disease.

The success or failure of whatever treatment the court may employ in such cases will in a great measure depend on the possibilities of each individual offender, and the adjustment of treatment to suit the particular needs of each case. Much can be done for an individual, even though he may suffer from physical and mental handicaps, providing an early diagnosis is followed by an understanding effort to treat his particular difficulties.

NOTES AND COMMENTS

California

A bill has recently been presented before the general assembly which would provide for the establishment of a psychopathic hospital to accommodate at least one hundred patients. The management of this hospital would be vested in a board of trustees, consisting of the medical superintendent of the state hospitals, the president of the California Medical Society, the deans of the medical departments of the University of California and Leland Stanford University, a neurologist, a psychologist and two other persons, the last four to be appointed by the governor. The bill states as the purposes of the hospital: "The study of abnormal mental states, their nature, causes, results, treatment and prevention; education regarding such abnormal mental states; the dissemination of knowledge in such matters; the care, observation and treatment within the wards of such hospital, out-patient department, or elsewhere in the state, of persons suffering from insanity and other abnormal mental states; the investigation in any part of the state into the primary or precipitating causes of insanity; to cooperate with local or state authorities and institutions in preventing abnormal mental states and aggravation thereof by unfavorable environment."

Another bill recently introduced would create a department of psychiatry and sociology at the state penitentiary at San Quentin. To quote from the bill: "Within ten days after this act goes into effect, the governor shall appoint a psychiatrist, a psychologist and a sociologist. The psychiatrist shall be the chief executive of the department of psychiatry and sociology, and shall have had training for at least one year in one of the state hospitals for the insane. Each member shall be appointed to hold office for a term of four years. The governor shall fill all vacancies created in said department by the appointment of the same kind of specialist as was his predecessor.

"It shall be the duty of the board of prison directors to make and adopt such rules as are necessary for the conduct of the business of the department of psychiatry and sociology; to provide equipment for said department with necessary furniture, fixtures, apparatus, appurtenances, appliances and materials for the proper conduct of said department.

"It shall be the duty of the members of said department to conduct an examination and investigation of the case of every person committed to the state penitentiary at San Quentin.

"It shall be their duty to define from a psychiatric, psychological and sociological standpoint, the type of problem presented in each case; to

make a scientific analysis of the various causative factors operative in each case; to outline the most promising plan of treatment for meeting at the same time the needs of social security and the individual prisoner's reclamation; to bring to the attention of the prison directors and the warden of the state penitentiary at San Quentin the method of treatment proposed in each individual case.

"It shall be the duty of the members of said department to make an annual report to the governor and prison directors, such report to include the plan of treatment suggested, the treatment given, and the result accomplished."

An appropriation of $30,000 for equipment, maintenance and salaries, is included in this bill.

The following bill relative to the reception and temporary care of persons suffering from mental disorder has recently been presented before the legislature of California:

"The superintendent of any hospital for the insane, public or private, may, when requested by a physician, or by a member of the board of health of the state, county, city, or city and county, or a peace officer of a city, town, county, or state, or by the judge or district attorney of a county, receive and care for in such hospital as a patient, for a period not exceeding thirty days, any person who needs immediate care and treatment because of mental derangement. Such request for admission of a patient shall be put in writing and filed at the hospital at the time of his reception, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the state board of insanity, giving such information as said board may deem appropriate."

Delaware

The institution for the feebleminded, authorized by legislative enactment in 1917, is to be located in Sussex County near Selbyville. The land which is valued at $39,000 was purchased through individual subscriptions, without cost to the state.

Georgia

The studies of the Georgia Commission on the Feebleminded have aroused a keen interest throughout the state. Public sentiment in favor of a state institution for the feebleminded has been created through the Commission's investigations of public schools, orphanages, jails, almshouses, reformatories, state prisons, and the special studies of juvenile court cases and of typical degenerate families. The work of the Commission has the sanction and hearty cooperation of medical associations, women's clubs, business men, teachers and parent associations. The State Federation of Labor at a recent meeting adopted resolutions strongly endorsing the work in behalf of the feebleminded

and urging the local organizations in the state to ask the support of their legislators for state provision for the feebleminded. The Commission expects to complete its studies by the end of May. Its report with recommendations will be presented to the legislature, which convenes in June.

Illinois

To relieve the overcrowding at the Lincoln State School and Colony, for the feebleminded, and to accommodate the large number of feebleminded awaiting admission, it is proposed to enlarge the new epileptic colony at Dixon to a capacity of 1,000 patients, and to admit feebleminded persons to it. The law creating the Dixon State Colony, in 1913, made admission voluntary on the part of the patient and, as a consequence, not more than 100 persons have made application for admission. It is not intended to abandon the epileptic colony, but to erect cottages in unit groups that will be well suited to the care of this class of patients, and to use the existing buildings for the feebleminded.

Indiana

A number of laws of special interest were enacted by the 1919 legislature of Indiana. One makes provision for a new institution for the feebleminded, to be built in the southern part of the state on a tract of land containing not less than one thousand acres. Another law provides for the court commitment of feebleminded children between the ages of six and sixteen years to the School for Feebleminded Youth, at Fort Wayne, upon the application of a reputable citizen of the county and after an examination by two qualified physicians. By the terms of another law, voluntary admissions to the state hospitals are authorized, and also the establishment of free mental clinics by these hospitals. Social workers and visiting nurses are to be employed in the prevention of mental diseases and after-care of patients who have left the hospitals. An appropriation of $350,000 for a colony farm has been made to the Central Hospital for the Insane, located in Indianapolis, and a special fund of $400,000 will make possible a further extension of the colony system. The Village for Epileptics has received a substantial appropriation for cottages for women. Heretofore, this institution has not been able to admit women. Additional cottages for men will also be provided. The erection of industrial buildings at four of the state institutions is provided for by the appropriation act. A division of venereal diseases and one of child hygiene have been provided for in the State Board of Health.

Iowa

A law "to better provide for the care and detention of feebleminded persons" has been enacted by the 1919 legislature, to become effective in July of this year. This law makes provision for the commitment of a

feebleminded person through the petition of a relative, guardian, or reputable citizen in the county of his residence, after he has had a court trial, a notice having been served upon him within ten days previous to the trial. The court may require the alleged feebleminded person to be examined by a qualified physician or a psychologist, and also may require the petitioner to answer under oath any questions propounded in a form prescribed by the Board of Control.

The hearing on the petition shall be by the court, and a commission to be appointed by the court, of two qualified physicians or one qualified physician and one qualified psychologist, selected by the judge.

If the alleged feebleminded person is found to be feebleminded, the court shall enter a decree, appointing a suitable person to be his guardian, or directing that he be sent to a public institution for the feebleminded or to a private one qualified and licensed under the laws of the state.

Another provision of the act states that when a child is brought before a juvenile court as a dependent or delinquent child, if it appears to the court that such child is feebleminded, the court may adjourn the proceedings and direct some suitable officer of the court or other suitable person to file a petition under this act; and the court may order that pending the preparation, filing and hearing of such petition the child be detained in a place of safety or be placed under guardianship of some suitable person.

This act also provides for the transfer of patients between the hospitals for the insane and the institution for the feebleminded.

Kansas

Senate Bill 553 provides for the voluntary admission to a state hospital for mental disease of any person making written application, provided he produces a statement from his attending physician, or from the county physician of his county, that he is in need of treatment, or the superintendent is satisfied that the applicant is in need of such treatment. Such patient shall not be detained longer than ten days after he has given notice in writing of his desire to leave the hospital.

A bill has been enacted by the 1919 legislature changing the name of the State Home for Feebleminded to the State Training School. Another law provides for a simplified form of commitment to this school. It permits the adjudgment of mental defect on the recommendation of two qualified physicians or of one physician and one psychologist, and allows commitment without the consent of parents or guardians.

Maine

Among appropriations made by the recent legislature are $125,000 for new construction at the two state hospitals, and $36,500 for the same purpose at the school for the feebleminded.

A progressive step in the legislation with reference to the commitment and care of persons with mental disease is Chapter 232, Laws of 1919, State of Maine. This act provides for (1) commitment for observation, by judges and other persons, upon the certificate of two physicians qualified as examiners in insanity; (2) voluntary admission to the state hospitals of persons desirous of submitting themselves to treatment; (3) temporary commitment of persons requiring care in a state hospital, for a period not exceeding fifteen days, upon the request of a physician, a member of the board of health, a health officer or a police officer; (4) community service. This last provision requires the state institutions for the insane, the feebleminded and the epileptic to organize community service, with the following purposes: (a) to supervise patients who have been discharged; (b) to inform and advise any indigent person, his relatives and friends or the representatives of any charitable agency, as to the mental condition of any indigent person, the needed treatment, and the institutions and the other means available; (c) to cooperate with other state departments; (d) to acquire and disseminate knowledge of mental disease, feeblemindedness, epilepsy and allied conditions.

Massachusetts

In the report of the special commission, created in 1918 by legislative enactment, to investigate and consider methods of treating inebriates, feebleminded persons, defective delinquents, criminals and misdemeanants, the following conclusions are found:

1. "The present disintegrated and unrelated system under which criminals and misdemeanants, both juveniles and adults, are confined and cared for in our 34 penal and correctional institutions must be replaced by a unified system, under state direction, if proper classification according to age, mental condition, and possibilities of reformation can be expected, or treatment that is remedial and economical obtained.

2. "The plant of the State Prison at Charlestown should be abandoned. The State Prison should be transferred from the site at Charlestown to the plant now occupied by the State Farm at Bridgewater, the State Farm to be transferred to the control of the Bureau of Prisons for this purpose.

3. "The Norfolk State Hospital, upon its return to state use, should be retained for the custody, care and treatment of inebriates and drug addicts, taking charge of all cases falling within that group.

4. "The principle of a clearing-house should be adopted in our process of court commitment of all offenders by which

   a. All adult offenders who are found guilty, and who, in the opinion of the court, should go to a penal institution, shall be committed to the custody of the Bureau of Prisons, or other state body dealing with adult offenders, instead of to the separate institutions, as at present.

b. All juvenile offenders who are found guilty, and who, in the opinion of the court, should go to a school or institution for juvenile delinquents, shall be committed to the custody of the Trustees of the Massachusetts Training Schools, or other state body dealing with juvenile offenders.

5. "The defective delinquent should be identified by a process of examination in the courts, and withdrawn from the community for custodial hospital treatment in accordance with his defective condition, instead of committing him for short-term sentences, as at present, with the certainty that he will repeat his offenses an indefinite number of times.

6. "Present beginnings in the identification and institutional treatment of those feebleminded persons in the community who are a menace to life and property, and are breeders of their own kind, should be extended

a. By mental examination, by a method approved by the Commission on Mental Diseases, of all persons detained in penal and correctional institutions;

b. By mental examination, by a method approved by the Commission on Mental Diseases, of all minors admitted to the State Infirmary, and of all women admitted there for confinement;

c. By mental examination, by a method approved by the Commission on Mental Diseases, of every child intellectually markedly retarded in the public schools;

d. By a centralized system of registration of all feebleminded, under the direction of the Commission on Mental Diseases;

e. By the development, under the Commission on Mental Diseases, of a process of supervising feebleminded persons in the community;

f. By the immediate extension of the Wrentham State School to its contemplated maximum capacity of 1,800 beds;

g. By the immediate development of the Belchertown plant to a maximum capacity of 1,800 beds."

The report also includes the following specific proposals for legislation:

1. "An amendment to our present laws, providing for the commitment of offenders to a public body in charge of correctional institutions, instead of to the institution itself.

2. "An act transferring the control of the State Farm from the Trustees of the State Infirmary and State Farm to the Bureau of Prisons, and transferring the State Prison from Charlestown to the land and buildings now occupied by the State Farm at Bridgewater.

3. "An amendment to Chapter 595, Acts of 1911, securing a clearer differentiation between the criminal features and the chancery functions of that law.

4. "An act providing for the compulsory mental examination, under the direction of the Commission on Mental Diseases, in all courts of all persons found guilty, who are repeaters, or who are suspected of being mentally deficient, for the purpose of carrying the defective delinquent law into effect.

5. "An act providing for a central system of registration of the feebleminded, under the direction of the Commission on Mental Diseases.

6. "An act providing for the mental examination of all persons committed to penal or correctional institutions, and of all minors admitted to the State Infirmary, and of all women admitted there for confinement.

7. "An act providing for the mental examination of all children of school age who are three or more years intellectually retarded, or who, in the opinion of the school authorities, are mentally defective; such examination to be made in accordance with a method approved by the Commission on Mental Diseases.

8. "An act providing for physical examination of all persons convicted of sex offenses, and authorizing the forcible detention of such as are found diseased, so long as their condition remains a menace to the public health. (No bill is submitted, as legislation is already proposed by others covering this head.)

"Bills embodying the foregoing recommendations are appended to this report."

These conclusions and recommendations for legislation are based upon the commission's careful study of the problems presented by (1) criminals and misdemeanants, (2) alcoholics and drug addicts, (3) defective delinquents, (4) female offenders with venereal diseases, and (5) the feebleminded. The report contains statistical data showing percentages of nervous or mental abnormalities found in inmates of penal and reformatory institutions of Massachusetts and other states, and also other data relative to recidivists in the various penal and reformatory institutions within the state.

The commission was composed of: Dr. Walter E. Fernald, Superintendent, Massachusetts School for the Feebleminded, Chairman; Ellen W. Gray, Chairman, Advisory Board of Prisons; Thomas W. White, Supervisor of Administration; Edward C. R. Bagley, Director of Prisons; Dr. George M. Kline, Director, Commission on Mental Diseases; and Robert W. Kelso, Executive Director, State Board of Charity, Secretary.

Minnesota

Chapter 407, Session Laws of 1919, authorizes the State Board of Control, with the approval of the state auditor, to select from public lands owned by the state a site for a colony for epileptics and a colony for feebleminded persons. Suitable buildings are to be erected upon such lands, and improvements made, as necessary, for the purposes.

The colony for the feebleminded and also the one for epileptics are to be established and maintained under supervision of the State Board of Control. Admission to these colonies will be under the same regulations as prescribed for admission to the School for Feebleminded and Colony for Epileptics, located at Faribault, of which institution these new colonies will be departments.

Missouri

In the summer session, for five weeks beginning June 16, at the Harris Teachers' College, conducted by the St. Louis Board of Education, courses will be offered for the preparation of teachers and examiners of backward and feebleminded children. One course includes manumental and industrial work for the backward and feebleminded, another is devoted to the clinical methods of examining mentally defective children; and a third course is given over to work in mental testing, including practice and observation. It is probable that a demonstration class will also be conducted.

New Hampshire

In accordance with Chapter 14, Public Acts of 1919, the authority over and supervision of the state hospital, school for feebleminded, industrial school, sanatorium for consumptives, and the state prison are vested in the governor and his council. A board of seven trustees is created for each of these five institutions. Five members of each board are to be appointed by the governor and council. The governor and a member of his council whom he appoints constitute the other two members of each board. The boards are to manage the institutions under the supervision and direction of the governor and council. The executive head of each institution is to be chosen by the trustees, subject to the approval of the governor and his council.

Another provision of this act authorizes the governor and his council to appoint a purchasing agent for a term of three years. It shall be his duty to purchase materials and supplies for these institutions, the normal schools, state library (except books and periodicals), and all departments quartered in the state house, except small and miscellaneous articles which the governor and council may authorize the head of any department to purchase. Whenever the commissioners of any county, the trustees of the New Hampshire College of Agriculture and Mechanical Arts, or the Soldiers' Home so desire, he shall purchase materials and supplies for them also.

It will be recalled that in 1917 a law was enacted in this state creating a board of trustees of state institutions for the management of the five institutions mentioned above. The powers and duties of these trustees shall cease upon the appointment of the trustees provided for by the new act.

New York

The so-called "Mental Deficiency Law," providing for a uniform state-wide commitment procedure for the feebleminded, which was summarized in the last issue of MENTAL HYGIENE, passed both houses of the legislature, with minor amendments, and has been signed by the Governor.

A new hospital recently established on North Brother Island, by the Health Department of New York City, will be devoted to the treatment of drug addicts. The hospital has a capacity of 200 beds, and will receive patients committed by the courts as well as self-committed persons who desire treatment.

New buildings which are now being constructed at Letchworth Village will make possible the care of 840 additional patients during the coming year, bringing the population up to about 1,200.

A bill that would authorize the establishment of psychiatric clinics in cities of the first and second classes and also in counties, designed to aid the criminal courts in the examination and trial of persons brought before these courts, failed of passage. It was intended that these clinics should aid the school, health and charity departments and serve other community purposes.

North Carolina

The juvenile court act of 1919, which provides juvenile courts for rural as well as urban populations, contains one section pertaining to the examination and treatment of children found to be mentally defective. The court has the right to cause any child who appears to be mentally defective to be examined by two licensed physicians, and upon their written statement that in their opinion the child is mentally defective, or epileptic, the court may commit such child to an institution authorized by law to care for the mentally defective or the epileptic, as the case may be. No child shall be committed to such institution, however, unless an opportunity for a hearing is given to parents, guardian, or custodian of the child.

A law has been passed by the 1919 legislature authorizing the sterilization of any inmate of a penal or charitable institution or hospital of the state, when in the judgment of the board created by this act the operation would be for the improvement of the mental, moral or physical condition of the inmate. The operation may not be performed until it has been affirmed by the governor and the secretary of the State Board of Health. This law further states: "At least one representative of the medical staff of the several charitable and penal institutions of the state, and one from the State Board of Health, such representatives to be designated by the governing bodies of the several institutions, shall

constitute a board of consultation for the carrying out of the provisions of this act. Said board shall cause a permanent record to be kept by one of its members, designated as secretary, of all its actions and judgments, taken at a meeting held only after due notice has been issued to all its members."

Pennsylvania

If House Bill 1141 becomes law, the Eastern Hospital for the Insane, authorized by the 1917 legislature and located at Selinsgrove, will receive an appropriation of $545,000, of which $45,000 is for the purchase of additional land, and $500,000 for the construction of buildings and improvements.

House Bill No. 1055, now in the hands of the Governor, aims to provide special classes for the education of extremely "backward" pupils in the primary grades. It requires every county and every district superintendent to secure information by the first day of October each year as to every child in each district between the ages of eight and sixteen years who because of exceptional physical or mental condition is greatly retarded in school work or who is not being properly educated, and to determine and report to the board of school directors of each district whether such child is a fit subject for special education. Proper education in special classes in the public schools or in special public schools must be provided for children reported to be fit subjects for special training. In case it is not feasible to form a special class with a minimum attendance of ten children in any district, or if for any reason it does not seem best to provide in the public schools of the district such education for any such child, the board of school directors may secure such training outside the school district in accordance with the terms of this act and other acts applicable to the training of such children.

School districts maintaining special schools and classes, approved by the State Board of Education as to location, constitution, size of classes, conditions of admission and discharge of pupils, equipment, courses of study, methods of instruction and qualification of teachers, shall receive from the state an amount equal to one half the total expense incurred in the maintenance of such classes and schools. The same provision is also made in case a board of school directors furnishes such education outside its district.

Tennessee

Chapter 150, Public Acts of 1919, which was approved by Governor Roberts April 15, provides for the establishment, construction and maintenance of the Tennessee Home and Training School for Feeble-minded Persons. This institution is to be constructed on the colony and cottage plan, preferably on lands already belonging to the state.

In addition to the court procedure outlined in the law, provision is also made for admission upon the application of the father, mother, or

guardian of the child, or any health officer or school official to the superintendent of the institution, if the applicant judges the child to be feebleminded and if the superintendent finds upon examination that the child is feebleminded. Provision is also made for the transfer to this institution of feebleminded persons now confined in the state hospitals for mental disease.

The superintendent is to be appointed by the Board for the Administration of State Institutions, and must be a graduate of a reputable medical college, of good moral character and with experience in the practice of his profession. Other officers, attendants and laborers are to be selected by the superintendent.

The act requires the segregation of sexes and separate maintenance of white and colored persons and of those convicted of felony.

Another provision reads as follows: "That the superintendent shall cause every person admitted to the institution to have, during the first month of his or her residence, a mental examination. Every person shall have, within the first two years of his residence, a second mental examination, and within the first five years a third mental examination. Case histories of all inmates shall be carefully filed and the following data shall be kept concerning each inmate.

1. "Physical examination

2. "Personal history (what sickness the person has had, at what ages and of what duration)

3. "Family history (nervous and mental diseases and defects in ascent or descent from the person in question and in collateral branches of the family)

4. "Educational history of the person before and after entering the institution (progress in school and other training work)

5. "Industrial history (at what employment has the inmate worked and with what success?)

6. "Civil and social relations (is the inmate married or single; and if a female, has she had illegitimate children? How many? Names? Ages?)

7. "Mental development (specific results of intelligence and other mental tests from time to time. Rating of the person in intelligence and in other essential elements in character formation)."

The act also provides for parole on the part of the superintendent, when he is satisfied that the inmate will be properly cared for and that his parole will not be detrimental either to the inmate or society. The parole must be cancelled and the inmate recalled to the institution whenever the superintendent learns that the welfare of the former inmate or of society requires it. The superintendent also has the power to discharge any inmate who, in his judgment, is not feebleminded.

The sum of $180 per year is appropriated for the maintenance of each person whose support is not otherwise provided for, either from his own

property or by some other person. A further appropriation of $10,000 is also made to be used for improvements, general repairs and equipment of property taken over by the Board for the Administration of State Institutions, and to be used for the Tennessee Home and Training School for Feebleminded Persons.

Another section of the act requires that private institutions for the feebleminded must be licensed by the Secretary of State upon the certificate of the Tennessee Board of State Charities. This certificate is issued only after the inspectors of the Board are satisfied that the superintendent is competent to diagnose feeblemindedness and to direct the care and training of feebleminded persons, that he has suitable grounds, buildings, equipment, personnel, etc.

Vermont

A law enacted by the 1919 legislature allows the commitment of women between the ages of 21 and 45 to the school for feebleminded. The commitment law of Vermont hitherto has applied only to children between the ages of five and 21.

An act approved March 14, 1919, allows the transfer of inmates from the industrial school and the school for the feebleminded to the state hospital. This law also authorizes the transfer of a patient from the state hospital to the state school for feebleminded. In each case the superintendent makes application to the State Board of Supervisors of the Insane for an examination of the person to be transferred. If in the judgment of the Board, after such examination, the person should be transferred, the Board notifies the governor in writing. The governor may then order such person transferred.

Washington

House Bill 123, which failed of passage, was designed to create a state commission to have supervision of the treatment of persons with mental disease and the feebleminded; to provide psychopathic wards for persons of curable mental state; to authorize voluntary admissions for treatment; and to create the office of state alienist. Another bill that was not enacted would have provided for special wards at each county hospital, for the care and observation of persons charged with insanity.

Canada

As a result of a survey of Manitoba made by the Canadian National Committee for Mental Hygiene, and in accordance with the Committee's recommendations, a law has been enacted by the Legislative Assembly of Manitoba entitled *The Mental Diseases Act*. Among other provisions is one for voluntary admission to the psychopathic ward of the Winnipeg

General Hospital or to the hospitals for mental diseases of any resident of the province who believes himself to be in need of treatment.

Another section of the act reads as follows: "Any person apparently insane and conducting himself in a manner which in a sane person would be disorderly may be apprehended without warrant by any peace officer or constable and brought to a justice of the peace or to two qualified medical practitioners who shall thereupon respectively deal with such person as in this Act provided in the case of other persons brought before them with the object of their being sent to the psychopathic ward or to one of the said hospitals."

By this act "The Selkirk Insane Hospital" becomes "The Selkirk Hospital for Mental Diseases" and the name of The Brandon Insane Hospital is similarly changed.

A section of the act designed to assist in making a census of the mentally defective or diseased is as follows: "Each municipal assessor shall, when making his assessment under *The Assessment Act*, ascertain and enter upon a blank prepared for that purpose and furnished by the clerk of the municipality the names and surname in full of all insane or idiotic persons in his assessment district not confined in a hospital, and the age, sex, occupation and place of birth of each of such persons and return the same to the clerk of the municipality at the time of completing the assessment roll for said district, and the clerk of the municipality shall, on receipt of the said roll, transmit such return to the Department of Public Works."

The law provides for the discharge of patients by the superintendent of the hospital.

The Lieutenant-Governor-in-Council may make rules and regulations for the management of the psychopathic ward and of each hospital. He may also appoint a medical superintendent for each hospital and the psychopathic ward, and such other officers as are required. He may from time to time, in case of necessity, authorize the temporary use of any buildings as hospitals for mental diseases.

Legislation for Defective Children in Missouri

The first Missouri Children's Code Commission, appointed by the Governor in 1915, submitted 42 bills of which ten were enacted into law by the 1917 legislature. The second Commission, appointed by the Governor in 1917, secured favorable action in the 1919 session on 25 of the 51 bills which were introduced. Plans are already being considered for the formation of a third Commission and for the reintroduction, in the 1921 session of the legislature, of the bills which failed. Only such bills will be referred to here as were introduced by the Children's Code Commission in the interest of defective children.

The new compulsory attendance law requires full-time attendance throughout the state of children between 7 and 16, unless they have

completed the eighth grade at 14 or 15. The act applies to the feebleminded, deaf, blind and crippled children where special classes have been provided for their instruction.

The establishment of special classes for the feebleminded, blind and deaf (the crippled were eliminated) is made mandatory in every school district in which there are ten or more children of each type. Moreover, "where two or more school districts each have less than ten children in each of these types, the boards of education of such school districts may contract with each other for the establishment of special classes . . . provided the pupils cannot be accommodated in the appropriate state institutions." Where no special classes have been provided, the State Board of Charities and Corrections is authorized to "provide for the proper training of feebleminded, deaf, and blind children under the age of sixteen years who have not attained the eighth grade in school." Where the parent or guardian is unable to bear the expense, the cost may be charged to the county in which the child resides. State aid is granted to the amount of $750 per year for each teacher wholly employed in any of these classes, provided she has received special training for the work "in accordance with the rules and regulations established by the state superintendent of public schools," and provided the amount of state aid shall not exceed two thirds of the salary paid the teacher by the local board. In New York and New Jersey the establishment of special classes for mentally retarded pupils is also compulsory. The acts in these states apply only to children retarded three or more years, and are so drawn that the classes will inevitably consist of both feebleminded and backward children.

The supervision of the instruction and the "designation of courses of study and necessary equipment" in all state schools for children is vested in the state superintendent of instruction: the schools for the deaf, blind, feebleminded and epileptic, and the girls' and boys' training schools and reformatories. It is also the "duty of the state superintendent of schools to examine teachers for the above-named institutions and grant certificates of qualification to those who pass a satisfactory examination. Only persons holding said certificates from the state superintendent of schools shall be employed as teachers in the above-named institutions." In only two or three other states in the Union is the instruction in institutions for the feebleminded placed under the chief educational officer of the state.

The commitment of the dependent, delinquent, criminal, immoral feebleminded is made compulsory after due process of petition, court hearing and certification by a "competent psychologist or competent physician, and no person shall be committed without a certificate of such psychologist or physician or a majority thereof." The persons contemplated by the Act are defined as follows: "The words 'feebleminded person' shall be construed to mean any person afflicted with mental

defectiveness from birth or from an early age, so pronounced that he is incapable of managing himself and his affairs and of subsisting by his own efforts, or of being taught to do so, and who requires supervision, control, and care for his own welfare, or for the welfare of others, or for the welfare of the community, and who cannot be classified as an 'insane person.'" This definition substantially corresponds to the definition in the English Mental Deficiency Act of 1913—which displaces the definition of the English Royal Commission—and is also practically the same as the Illinois Commitment Act of 1915. It will be observed that all of these definitions are based on social considerations, without any attempt to define feeblemindedness in terms of an arbitrary age-level, as in the California Act, according to which the feebleminded "will not develop beyond the level of the average child of twelve years."

The act for the enlargement of the colony for the feebleminded and epileptic provides, "as soon as the funds therefor are available," for the segregation of the epileptics into separate colonies, for the segregation into "separate colonies or institutions or if this is impossible, then into separate wards or detached cottages, of all feebleminded delinquents, prostitutes, children and other classes of inmates, who for their own welfare or for the welfare of other inmates should be segregated," for the establishment of "a separate cottage or cottages for the colored inmates," and for the establishment of "other colonies in temporary or permanent camps, in connection with the central colony at Marshall, at any place or places in the state where the inmates may be profitably employed and their welfare better secured." Unfortunately the fruits of this advanced legislation with respect to the commitment and colonization of the feebleminded cannot be immediately reaped because of the inability to secure funds for the enlargement of the colony, which now contains less than 600 inmates while the number on the waiting list has for several years been considerably larger. The appropriations voted by the legislatures in 1915 and 1917 were vetoed by the governors because of the failure of the legislatures to provide the revenues.

The bill for the prevention of the marriage of the "insane, mentally imbecile, feebleminded and epileptic," was defeated by both houses, while the bill for the establishment of a State Bureau for Mental Defectives which was passed by the House, was lost in a Senate filibuster, which was responsible for the defeat of thirteen other bills passed by the House.

The Illinois Society for Mental Hygiene

The Illinois Society for Mental Hygiene has been reorganized and has adopted a new constitution and by-laws designed to extend the activities of the Society throughout the state. The officers are to consist of a president, not more than three vice-presidents, a treasurer and a secretary, and are to be elected by the board of directors. This board is to

consist of not more than sixty members of the Society to be elected by a majority vote at the annual meeting and to serve four years. This board is also to appoint a committee of four to act with the president as an executive committee.

The officers of the Society are as follows: Anna Hamill Monroe, President; Harry Olson, Mary H. Wilmarth, Sidney D. Wilgus, M.D., Vice-Presidents; John S. Broeksmit, Treasurer; and Mrs. George Deane, Secretary.

The members of the Executive Committee are: H. Douglas Singer, M.D., Chairman; Sydney Kuh, M.D.; Cyrus McCormick, Jr.; Mary Rozet Smith; and Anna Hamill Monroe (*ex officio*), Secretary.

The Executive Committee has adopted rules which include the employment of a full time medical director and the subdivision of the activities of the Society into two departments (1) Social Service (2) Henry B. Favill School of Occupations, each with a superintendent and such workers as are necessary.

The New York School of Social Work

The New York School of Social Work, formerly called the New York School of Philanthropy, offers a summer session, from July 7 to August 15. This session is planned for teachers, ministers, nurses, and other professional workers, students in theological schools, volunteers, social workers who may wish to concentrate on technical problems in their particular field of work, college seniors and those who may wish to obtain advance credit on entering the School as regular students. One of the courses offered is in social psychiatry and is conducted by Dr. Bernard Glueck. It will include a discussion of the prevalence and social bearings of insanity, feeblemindedness, epilepsy, and neurotic conditions, with particular reference to social control and relief. Case histories will also be studied in connection with this course.

Mental Hygiene Conference Center

As the result of the need expressed by Associations, social workers and others for a place where persons with mental maladjustments of the less pronounced degrees may receive attention without the implication of seriousness which a hospital often arouses, the National Board of Young Women's Christian Associations has opened a Conference Center to which women and girls may be referred for advice and treatment. It is expected that the majority will be received from medical or social sources, but the Center is available for women and girls referred in any way.

The value of the work will depend to a large degree upon the cooperation of the agent who refers the case. The Center does not plan, except in a very limited degree, to institute social service mechanisms but to work whenever possible with those already existing.

The Center is located at 313 Flatiron Building, New York City. The staff includes Alberta S. B. Guibord, M.D., Mabel R. Fernald, Ph.D., Anne T. Bingham, M.D., and Almena Dawley.

Canadian Journal of Mental Hygiene

Persons whose interest or whose work brings them into contact with mental problems will welcome the new *Canadian Journal of Mental Hygiene*, the first number of which has recently been issued. This publication has the same scope and aims as Mental Hygiene and will contain articles which are non-technical in nature, reports submitted by recognized authorities, and other material designed to interest and instruct the Canadian public in the field of mental hygiene. The following articles are published in the April, 1919 number: *The Function of a Psychopathic Hospital*, by E. E. Southard, M.D., Director, Psychopathic Department of the Boston State Hospital; *The Scope and Aims of the Mental Hygiene Movement in Canada*, by C. M. Hincks, M.D., Associate Medical Director and Secretary, Canadian National Committee for Mental Hygiene; *The Story of the Toronto General Hospital Psychiatric Clinic*, by C. K. Clarke, M.D., LL.D., Medical Director, Canadian National Committee for Mental Hygiene; *Some Remarks on the Neuroses of the War*, by H. P. Wright, M.D., Major, C.A.M.C., Montreal; *Immigration, Past and Future*, by W. G. Smith, B.A., Professor of Psychology, University of Toronto; *Immigration and the Canadian National Committee for Mental Hygiene*, by J. D. Pagé, M.D., Major, C.A.M.C., Chief Medical Officer, Port of Quebec; *Social Service and Mental Hygiene*, by R. M. MacIver, D.Phil., Professor of Political Economy and Acting Director, Department of Social Service, University of Toronto; *Subnormal Intelligence as an Educational Problem*, by Peter Sandiford, M.Sc., Ph.D., Professor of Psychology, Department of Education, University of Toronto.

An account is also given of the purposes and activities of the Canadian National Committee for Mental Hygiene, showing the work that has been accomplished by the Committee during the first year of its organization. A brief account of the mental hygiene survey in Manitoba and recommendations to the Manitoba Government are presented. An interesting foreword in the form of an editorial, showing the nature of the problems in Canada and the purposes of the Committee and its publication, precedes the articles, and the final pages of the magazine are devoted to notes and news items.

Courses in Social Work at the University of Toronto

The Department of Social Service of the University of Toronto has recently issued an announcement of its extension courses to begin April 21. The courses are arranged with two objects in view, one course being intended especially for those who wish to enter the field of mental hygiene. This course is being given with the aid and at the request of the Canadian

National Committee for Mental Hygiene and is designed to give in a short period such initial training as will enable the student to meet the problems of social service in this field. A second course is intended for those who are unable to take the regular course of the department, but who wish to have some special training in social work. Instruction will be given in psychiatry, social and economic problems, neurology, mental tests, case work, social institutions, occupational therapy, child welfare, home economics and recreation.

Visits of inspection will be made to institutions and agencies in and near Toronto and a minimum of ten hours per week in the work of the psychological clinic of the Invalided Soldiers Commission will be required. Additional information may be had upon application to the Secretary of the Department of Social Service of the University.

Mental Hygiene Clinics and Health Centers

Dr. Walter B. James, formerly Chairman of the New York State Commission for the Feebleminded, in a recent number of *Health News*, the monthly bulletin of the New York State Department of Health, writes as follows:

The proposal of the State Department of Health to establish health centers throughout the state, in order to furnish to the people of the small cities and the country districts aid in the maintenance of health which is not now to be had, marks a distinct advance in our view of the duty of such a department to the public.

The following suggestions are made with a view of widening the usefulness of such health centers and of securing even broader health service to the people of the state. The Department of Health is not alone in being concerned with state health problems, there being many other divisions of the government which are almost equally interested. The importance of mental health as well as its relation to bodily health is daily becoming more and more widely recognized.

There is a universally admitted need throughout the state for an extension of the opportunity for having mental examinations made of persons whose intellectual soundness is suspected. This need is felt by at least seven important state agencies: The State Hospital Commission, the State Commission for the Feebleminded, the State Department of Health, the State Department of Education, the State Commission of Prisons, the State Probation Commission and the State Board of Charities with its numerous affiliated associations.

In addition to these state agencies, there are closely affiliated private organizations which also have a very direct interest in the establishment of such clinics, especially the State Charities Aid Association, which has already done a great deal of most valuable clinical work along this line and which has stimulated the establishment of mental clinics by the State Hospital Commission.

The State Hospital Commission now has between twenty and thirty clinics, many of which are doing successful work, but these are not extensively or generally used by the other agencies above mentioned and it seems unlikely that they will be so used unless the remaining state departments can have some part in and some responsibility for them.

The present plan for state mental clinics, therefore, proposes a board of joint control, to consist of one of the leading officers of each of the above mentioned seven agencies. This board has already been formed at a meeting at which all of the organizations were represented. It is proposed that it encourage the creation of clinics throughout the state wherever they may be found to be needed. It is intended that, for the most part, the clinics shall be maintained by local agencies already existing, such as hospitals, dispensaries, county boards of child welfare and others.

Thus it is clear that this plan is merely an extension of the health center scheme which is being developed by the State Department of Health. This department had already considered having a room for mental hygiene in connection with the various health centers and it is possible, indeed, that it may seem wiser to drop the name "mental clinic" and in each case merely to call the agency a "health center" and to develop gradually in each such center all of the activities that can be made of value to the inhabitants of the district. It is not intended, and this should be clearly understood, to establish departments of medicine and surgery, or to furnish a substitute for the medical and surgical advice that is already adequately provided throughout the state by practitioners of medicine, but rather to cover ground which at present is not covered, especially in the abnormalities of the mind.

Special services will be furnished from the staffs of the State Hospitals for the Insane, from the State Commission for the Feebleminded, the Board of Education and the State Board of Charities and its institutions, and the State Department of Health. It is believed that in this way a maximum of service to the people of the state can be had at a minimum of cost through the utilization of agencies already existing. It is the intention of the board of control to begin with the creation of such clinics in five or six selected towns, where immediate cooperation and interest can be had, and it is hoped and believed that from this beginning a state-wide system can be gradually developed.

It has been thought best that at the outset the Board of Control of Mental Clinics, or, as it may be called in the future, of "Health Centers," should be informally created and not by act of legislature. Later, it may seem best to make it a matter of legislative enactment.

The idea of such a clinic is not a new one, as it already exists in an admirable form at Waverley, Massachusetts, where it is conducted by Dr. Fernald, head of the institution for the feebleminded. The present

plan proposes to make the invaluable services of such a clinic as Waverley available to as many as possible of the citizens of the state.

Such a clinic would naturally operate somewhat as follows: There would be a fixed day when patients could be brought for preliminary study, when the various mental tests would be made, the history taken, perhaps a physical examination made and when an inquiry into the environment of the patients could be started. On a subsequent date, a few days later, the patients would be again brought to the clinic, when the State Hospital psychiatrist especially chosen and fitted for such work, and who would be at the head of the mental division of the center, having all of the above data prepared and recorded, would make a diagnosis, arrive at a conclusion, put the patient upon rational treatment and give the wisest counsel.

It is believed that such a system would provide as widely as possible for the citizens of the state the benefits of the best modern knowledge of mental disorders which are not available today. The experience of the new American army in relation to psychiatry and the valuable facts and principles that have been accumulated through the labors of the psychiatric division of the army, have made it even more evident than it was previously, that great benefits can be made to accrue through the early detection and the skillful management of the mental disorders and abnormalities and maladjustments that are so common throughout the community.

The plan, as outlined, contemplates cooperation between a number of distinct and independent state mechanisms and the utilization in common of the resources of these for the attainment of a common aim. This is a principle which may be somewhat new in governmental relations, but it has so much to commend it that it seems more than worth while to attempt a successful accomplishment.

Mental Defectives in Indiana

The second report of the Indiana Committee on Mental Defectives has recently been transmitted to the Governor. The first report, it will be recalled, was presented in 1916. This second report comprises a survey of eight counties which are representative districts of Indiana. The purpose of the study was to determine first, where; second, of what type; third, how dangerous to the community; and fourth, how many are the mental defectives in Indiana. The following were the sources of information of the investigators: physicians, school authorities, township trustees (overseers of the poor), persons or organizations interested in community welfare, state records of charitable and correctional institutions, county clerks' records, county judges and county prosecutors.

In this survey the term mental defective includes the insane, the epileptic and the feebleminded. "An insane person is one incapacitated

as the result of a mental disease." An epileptic is defined as "a person subject to 'falling sickness,' or periodical convulsive seizures, generally called epilepsy." Feeblemindness is defined as an "arrest of development somewhere between infancy and twelve years of age. It may be defined as a 'state of mental defect existing from birth or an early age, and due to incomplete or abnormal mental development, in consequence of which the person afflicted is permanently incapable of performing his duties as a member of society in any position.'" The classification of feebleminded into idiot, imbecile and moron is also presented.

After a discussion of the data for each of the eight counties, the following topics are treated: Mental Defectives and School Children; Relation of Mental Defectiveness to Pauperism; Mental Defectives among Dependent Children; Mental Defect in Relation to Delinquency and Crime; and Defectives in the Community. A few histories of individuals and also of families are presented, illustrated by charts.

The following conclusions are presented:

1. "Existing social conditions are complicated by the presence of defectives in the community.

2. The value of reconstruction plans for the future will be discounted by the defectives employed by our industries and by those forced into idleness because of unfitness.

3. Education of the public regarding the facts relative to mental defect is necessary to the solution of the problems arising therefrom.

4. The counties studied in the survey were selected because they represented communities typical of Indiana for location, resources and industries.

5. At a conservative estimate, 2.2 per cent of the general population is mentally defective, i.e., either feebleminded, insane or epileptic. On this basis Indiana has 59,419 defectives.

6. Of these 59,419 defectives, 5,192 are in the state hospitals for the insane; 1,409 are in the School for Feebleminded Youth, and 348 are in the State Village for Epileptics.

7. On the basis of the percentage obtained from the eight counties, Indiana has in the community, outside of public institutions

20,526 feebleminded needing institutional care.
20,796 feebleminded not needing institutional care.

Total 41,322 feebleminded in the community.

Of our feebleminded now needing institutional care 6.4 per cent are in the School for Feebleminded Youth at Fort Wayne.

8. On the same basis, Indiana has in the community outside of the five hospitals for the insane

1,482 insane persons needing institutional care.
1,593 insane persons at present not needing institutional care.

Total 3,075 insane in the community.

Of our insane now needing institutional care 78 per cent are in the state hospitals for insane.

9. On the same basis Indiana has in the community outside of the State Village for Epileptics

1,296 epileptics needing institutional care.
2,538 epileptics not needing institutional care.

Total 3,834 epileptics in the community.

Of our epileptics now needing institutional care 21 per cent are at the State Village for Epileptics."

The committee recommends:

1. The enlargement of the Village for Epileptics and additional provision for the care of women at this institution.

2. Increased accommodations for the insane.

3. The construction, in connection with the state hospital for care of medical and surgical cases, of a psychiatric department for observation and treatment of incipient mental cases.

4. The establishment of detention wards at other general hospitals for observation and detention pending commitment and admission to the state hospitals.

5. A law providing for voluntary admission to and temporary detention in state hospitals.

6. Additional provision in the way of farm colonies for feebleminded.

7. A law providing for commitment to the School for Feebleminded Youth, the same as to the Village for Epileptics.

8. Mental examinations of school children.

9. Free mental clinics in connection with the state hospitals, and the state institutions for the feebleminded and the epileptic.

10. A law to prohibit confining insane, feebleminded or epileptic in any county jail pending admission to a state institution.

11. Development of occupational therapy for patients.

12. Prevention of mental defect, (a) through the officials of the state assisting in the operation of the Federal anti-vice laws; (b) by their helping in the operation of the Harrison law limiting the use of drugs; (c) by keeping Indiana as dry in fact as in theory; (d) by enactment of laws declaring the mental age as the legal age; (e) by requiring of physicians in their application for licenses a more technical knowledge of nervous and mental disease and mental defect, and by making provision for the adequate education of medical students and physicians in these subjects.

13. The enactment of a law providing for the continuance of a commission to study the entire question of mental defectives in Indiana.

In a recent number of *Flying*, Major R. W. Schroeder, U. S. A., A. S., gives a striking account of how he attained the world's altitude record. One of the most interesting features of Major Schroeder's story is the description of his sensations and altered judgment when at the high altitude. Major Schroeder writes:

"In order to take an aeroplane to a higher altitude than any other pilot in the world, I found that it would require more than one or two attempts. I made three attempts. The first one took me to an altitude of 24,000 feet, the second to 27,000 feet and the last one to 28,900* feet; but now I feel certain that with a few changes and improvements, I can get to 30,000 feet or better.

"The altitude reached is only 102 feet short of the highest mountain peak in the world, the great Himalaya peak, which is 29,002 feet high. Most people cannot stand high altitudes, and from 10,000 to 15,000 feet they bleed at the nose and ears. I had been to 12,000 feet at different times and experienced no difficulties. After being put in charge of the Testing Squadron at Wilbur Wright Field, my duties required me to go to the ceiling with all new types of high-powered battle aeroplanes, which were being experimented with by the United States Government. (By ceiling, I mean the highest altitude that the aeroplane can reach.) During these trips I would quite often go without the use of oxygen, and in time I discovered that I was becoming accustomed to the rare, thin air. However, I did not seem to be able to go above 23,000 feet at any time without feeling a sort of sleepy, tired, cross and hungry feeling, which I was unable to overcome except by the use of oxygen. Without the use of oxygen at these altitudes, I would feel that I was doing everything just right, and even if the aeroplane would get into some critical position and I could see when I looked down that the earth that should be underneath me was not there any more, but was way over on the other side of the machine, yet I believed that I was flying all right, and that my flying position was right, but the earth was in the wrong place. So after having these experiences, I decided that I would have to overcome these dangers, and the way I did it was to keep my mind on one thing; and that was, when the earth is in the wrong place, use oxygen. This I did, and found that it worked out very well.

"The cold, thin air is one's great adversary. First of all, one must make a study of the performance of his motor at these high altitudes. This I did, and made the necessary changes each time before trying again. A very positive oxygen regulator and face mask should be used. These were unobtainable, for the sets I had previously tried out had failed to function above 21,000 feet. Furthermore, the face mask pressed so tight to my face that it interfered with the flow of blood and my face grew numb, so I used a rubber hose direct from the oxygen bottle, which I regulated with a valve on the bottle. The hose was placed in my mouth

* This height has recently been exceeded.

so that I could breathe air and oxygen at the same time. I also pressed my tongue against the end of the hose in order to tell if the oxygen was still flowing. This method was very satisfactory, except that the oxygen bottle and the rubber tube gathered about a quarter of an inch of frost, which made it very unpleasant.

"The following experiences and sensations I noticed during my flight were due to lack of oxygen. I took off at 1:45 p. m., Wednesday, September 18, 1918, and made a steady circular climb, passing through clouds at 8,000 feet, 12,000 feet and 16,000 feet. While still climbing in large circles my goggles became frosted, making it very difficult for me to watch my instruments. The temperature at this altitude was two degrees below zero, centigrade. When I reached 25,000 feet I noticed the sun growing very dim, I could hardly hear my motor run, and I felt very hungry. The trend of my thought was that it must be getting late, that evening must be coming on and that was the reason the sun was getting so dim. But I was still climbing, so thought I might as well stick to it a little longer, for I knew I could reach my ceiling pretty soon, then I would go down and, even though it were dark, I could land all right, for I had made night landings many times before; and so I went on talking to myself, and this I thought was a good sign to begin taking oxygen, and I did. I was then over 25,000 feet and the temperature was 60 degrees centigrade below zero.

"As soon as I started to inhale the oxygen the sun grew bright again, my motor began to exhaust so loud that it seemed something must be wrong with it. I was no longer hungry, and the day seemed to be a most beautiful one. I felt like singing with sheer joy as I gazed about through the small portion of my goggles, which had no frost, due to a drop of oil which had splashed on them from the motor.

"It was wonderful to see the very clear blue sky with the clouds thousands of feet below. The frost on my goggles bothered me very much. At times I had to remove my glove in order to put the warm palm of my hand on the glass to thaw the frost. I did this every few minutes so that I could take the proper readings of the instruments, which I marked down on my data pad. I believe that if my goggles had been better ventilated they would not have frosted. When I was about 27,000 feet, I had to remove my goggles, as I was unable to keep a steady climb. My hands by this time were numb and worried me considerably. The cold, raw air made my eyes water and I was compelled to fly with my head well down inside the cockpit. I kept at it until my oxygen gave out, and at that point I noticed my aneroid indicated very nearly 29,000 feet. The thermometer showed 62 degrees below zero, centigrade. The lack of oxygen was affecting me and I was beginning to get cross, and I could not understand why I was only 29,000 feet after climbing for so long a time. I remember that the horizon seemed to be very much out of place, but I felt that I was flying correctly, and that I was right and the horizon was wrong.

"About this time the motor quit, I was out of gasoline, the propeller stopped and everything was quiet, so down I went in a spiral. When I had descended to about 20,000 feet I began to feel much better, and realized that the lack of oxygen had affected me. I passed down through the clouds at 16,000 feet, and, as I remember, it was snowing from these clouds upon the next layer, some 4,000 feet below. I am not positive as to this, as I may have been affected by the lack of oxygen. I noticed as I descended that the air seemed to be thick and stuffy, but very nice and warm.

"During the entire trip I did not see the ground, from the time I went up through the clouds above Dayton, Ohio, until I came down through the clouds again at 4,000 feet above Canton, Ohio, over 200 miles from where I started.

"I was lost, beyond a doubt, with a dead engine, over very rough country. I landed O. K., but broke the tip of my propeller, which was standing vertical, when I rolled into a depression in the ground. However, I did not nose over or do any other damage to the aeroplane or myself.

"My hands and face were numb, my lips and four of my fingers were frozen and required medical attention. Electrically heated clothing would have been very well used, but I dressed as light as possible to avoid the extra weight, as I had stripped the entire aeroplane of all unnecessary load. This was done to assist me in climbing.

"Two barographs were arranged in the aeroplane, which recorded the climb on a small paper drum. I also had a thermometer out on the wing strut, which showed the temperatures. The two barograph papers and the temperatures were sent to the officials of the Aero Club of America, who called a meeting of their Board of Governors, and the result of their meeting gave me an official world's altitude record of 28,900 feet. The Club has sent notification of this record to the International Aeronautic Federation and to the Pan-American Aeronautic Federation, so that the record will be recognized by all the aeronautic bodies all over the world."

Military Hospital for Mental Diseases

A new military hospital for mental diseases is to be established at London, Ontario. The plan calls for six ward buildings and one administrative building. This hospital is intended primarily for patients with war psychoses rather than war neuroses.

War Neuroses

Editorial, *Boston Medical and Surgical Journal*

An article of unusual interest, considering with intelligence and insight the condition of war neuroses, has appeared recently in the *Atlantic Monthly*. The author, Frederick W. Parsons, remarks that we have all heard stories, especially at the beginning of the war, of the queer

behavior manifested by men who have been exposed to particularly violent bombardment; the term "shell shock" became popular, and was soon applied to almost any unusual mental or nervous condition. This article considers the psychological aspects of the development of war neuroses, pointing out that the symptoms of war neuroses are not essentially different from peace-time neuroses, although they may assume slightly different forms because of the environment of war. The psychological principles of Freud are believed to be important in the production of peace-time neuroses; the individual, unable to adjust himself to a difficult situation, escapes by an unconscious avenue. In war neurosis also, the results of a true neurosis are never conscious and voluntary. Although the causes of war neuroses are many, the foundation of the condition may be traced usually to a difficult situation, whether it be lack of courage, association with uncongenial natures, a sense of injustice; or brooding over real or fancied wrongs. This internal mental conflict, added to poor sleeping, exposure, perhaps hunger, and the explosion of a shell near by, often result in a state of unconsciousness, sometimes followed by blindness, deafness, and loss of voluntary control over the motions. It is a mistake, however, to attribute these conditions to the shell explosion alone. They are the outcome of maladjustment in war as in peace.

The author of this article depicts also the attitude of the psychoneurotic individual who enjoys his neurosis greatly more than the life which caused it, and therefore clings to his symptoms. Either an oversympathetic attitude or neglect may end in making permanent invalidism a result of what should be only a passing phase. An intelligent and sympathetic understanding on the part of the public will greatly benefit men who are returning to this country suffering from war neuroses.

A Layman's Account of the Prevention of War Neuroses

In a series of published articles in *Collier's* on the Meuse-Argonne offensive, Arthur Ruhl, the war correspondent, speaks of the work done in an American Field Hospital to prevent the fixation of war neuroses. His reference brings out so clearly the task of the division psychiatrist during combat that we reproduce the following paragraphs:

"An inspector, experienced in nervous disorders, sorted them at the door—for in the hurry of the aid stations 'shock' is almost as easy a diagnosis as 'gas'—and admitted only those who could not be taken care of elsewhere.

"'What's wrong with you, my lad? Wounded? No? Gas? You're all right—just tired out, that's all. We'll give you something hot and a place to sleep, and in a couple of days have you back with your company.' This 'back with your company' idea was accented at once. The notion of the interior and a long period of convalescence was not, if it could be prevented, permitted to get a start. Even men quite unstrung

were treated—if not wounded and able to stand it—in the same heroic fashion. The idea was to get the paralyzed machine functioning normally as soon as possible—not to let the soul sickness become chronic.

"One boy came in trembling like a terror-stricken horse and jerking his hands and arms. He had almost lost the power of speech. 'What's your name, son?' the doctor demanded briskly. The boy stared wildly into space and made no reply. 'What—is—your—name?' repeated the doctor severely. 'Come, come, you've got a name!' The boy pulled himself together and exploded, rather than answered: 'Johnson!' 'What's your other name? You've got a first name. Come—out with it!' The boy made another effort, and finally articulated 'William!' The doctor went on from question to question—not because the information was of any importance, but merely to get the machine running again. An hour later the same man stood in line with a lot of others, waiting for 'chow' and coffee—not quite himself again, for he started when anyone came up behind him, but talking with the man next to him and well on the way."

Care of Compensable Insane by the Federal Government

By order of the Secretary of War, the following circular (225), issued under date of April 30, 1919, outlines the procedure with reference to treatment of the compensable insane soldiers after their discharge from the Army.

1. The Bureau of War Risk Insurance is charged by law with the duty of caring for the compensable insane of the military service after their discharge from the Army, and has undertaken to provide institutional treatment after discharge for cases requiring it. Such cases are to be turned over directly to the care and responsibility of the Bureau in such a manner that there will be no interval between discharge from the military service and the commencement of the continued care in hospitals near their homes which is to be provided by the Bureau.

2. In order to accomplish this, the following procedure will be observed:

a. Cases which have been under treatment in military hospitals in this country for four months, and which are considered to be incurable or to require a much longer period of hospital treatment to effect a cure, will be reported in writing by the commanding officer of the post, camp or station directly to the Chief Medical Adviser, Bureau of War Risk Insurance, Washington, D. C. (attention Section of Nervous and Mental Diseases), who will give instructions as to the disposition desired by the Bureau of War Risk Insurance. When reporting cases to the Bureau of War Risk Insurance under this paragraph, the following information regarding the soldier will be furnished: (1) name, rank, organization, Army serial number and race; (2) length of service; (3) legal residence; (4) name and residence of nearest relative; (5) diagnosis; (6) brief summary of medical history; (7) prognosis.

b. Upon receipt of instructions from the Bureau of War Risk Insurance, the soldier will be ordered discharged on certificate of disability by the authority designated to order discharge in such cases. The same procedure as to preparation and disposition of records will be followed as outlined in Army Regulations governing the discharge of insane in the military service and their delivery to institutions. The soldier will be delivered to the designated institution accompanied by necessary attendants and not discharged until his arrival thereat. When the soldier has been delivered to the authorities of the institution designated to receive him, the senior attendant will ordinarily telegraph the commanding officer authorized to discharge the soldier. Upon receipt of this information the soldier will be discharged and discharge papers mailed to the authorities of the institution to which the soldier was transferred for delivery to the soldier. When a patient is delivered to an institution and discharged, the Bureau of War Risk Insurance will be so informed in writing by the commanding officer concerned.

3. This circular does not in any way amend subparagraph *a*, Circular No. 188, War Department, 1918, relative to the discharge of a certain class of patients who possess funds or have relatives or friends who can afford them specialized care after discharge.

Lieutenant-Colonel E. G. Zabriskie, of New York City, has been designated Senior Consultant in Neuropsychiatry for the American Expeditionary Forces, succeeding Col. Thomas W. Salmon, who has returned to the United States. Lieutenant-Colonel Zabriskie went to France as divisional neuropsychiatrist of the Fourth Division. Subsequently he was consultant in neuropsychiatry to the Third and Fifth Corps and the First Army. After the armistice he served as consulting neuropsychiatrist to the Savenay hospital center.

Library Notes

A growing interest in mental health problems is evidenced by the unusually large number of requests for literature and information that have been received by the Library of the National Committee for Mental Hygiene during the past three months.

Among new bibliographies compiled by the Library and available for distribution in limited quantity are: *List of Correlative Reading for the Training School of Psychiatric Social Work at Smith College; Literature on Careers of Mental Defectives; References on Industrial Psychology; Selected References on the Relation of Mental Disease and Defect to Delinquency*—a former bibliography brought to date; *Selected References on Child Training and Psychology; Reading List for Psychiatric Social Workers.*

Over one hundred new books and nearly 600 reprints and pamphlets on psychiatric, neurologic and social subjects have been added since the beginning of the year to the Library's collection of literature. These

books and most of the pamphlets may be loaned to persons interested in the field of mental hygiene, who can present proper references, and a collection of more than one hundred sets of periodicals is available for reading and research in the Library.

A new periodical, *The Journal of Industrial Hygiene*, issued its first number in May. It promises to be a journal of unusual interest and value to the field of industrial medicine. The Editors are David L. Edsall, A. F. Stanley Kent; Honorary Consulting Editor, Thomas M. Legge; Associate Editors, W. Irving Clark, Jr., Alice Hamilton, Emery R. Hayhurst, Yandell Henderson, William H. Howell, Frederic S. Lee, Harry E. Mock, J. W. Schereschewsky, C.-E. A. Winslow; Managing Editors, Cecil K. and Katherine R. Drinker. The magazine is published monthly by The Macmillan Company. An especially noteworthy feature is the Supplement entitled *Abstract of the Literature of Industrial Hygiene*. About two hundred periodicals, including foreign publications, will be examined systematically for material pertinent to the subject of industrial hygiene. This list of periodicals to be abstracted will be constantly extended to include foreign publications that are being revived after suspension during the War. The abstracts are classified under headings indicating the subjects treated. Another feature of interest in the May number is the scholarly article entitled *The Problem of Fatigue* by Reynold A. Spaeth, Associate in Physiological Hygiene in the School of Hygiene and Public Health, Johns Hopkins University. This article is supplemented by a very inclusive and valuable bibliography of the subject of fatigue and its effects.

ABSTRACTS

THE RELATION OF THE PSYCHIATRIST TO THE GENERAL PRACTITIONER
By C. Macfie Campbell, M.D. *Maryland Psychiatric Quarterly*, 8: 59–64, January 1919.

The general practitioner of today does not hesitate to appeal to the specialties when he desires aid, but at present psychiatry is a branch of medicine probably less known to him than any other. The indications that a psychiatric examination is necessary are not so clear to him as are those, for instance, demanding a laboratory examination of fluids of the body or an eye examination, etc. He is apt to consider so-called "mental symptoms" as having no bearing upon the physical condition. He, therefore, omits to consider how the case might look if the psychiatric data were taken into account, and is likely to ignore the fact that the key to some symptoms is to be found only by this approach.

The general practitioner is apt to disregard the connection between mental processes and the activities of the whole system. It must be remembered that "we think with our glands as well as with our head." Thought may be used as a term to denote an aspect of the process of adjustment to environment, but in adjustment the whole mechanism of the patient is involved.

Patients may show their emotional reactions in different organs. For instance, a middle-aged woman had suffered for years from stomach trouble; she had acid stomach, much gas, and could not digest her food. But a thorough examination of her digestive apparatus by an internist showed no basis for her chronic invalidism. The real trouble lay in the fact that she could not digest the presence of a rival in her house and "in her emotional reactions gastric symptoms were apt to be rather prominent."

The psychiatrist studies these reactions of the patient. When an ordinary medical examination shows no basis for the symptoms the internist frequently suspects more complex factors such as the psychiatrist deals with, but when he finds a physical basis for the symptoms he is frequently content to ignore the possibility of more complex contributing causes.

The author gives examples of sciatica as a result of family friction. The symptom of headache is one of the most common in response to difficult situations. Some people have a constitutional tendency to recurrent headache. These two factors may combine in the individual case.

"One patient herself commented on the fact that she had no headache on the afternoons when there was the weekly party; another patient,

from a headachy family, who had suffered from recurrent headache, was weaned from her complaint when she realized that the headache had been her weapon for getting constant change of environment and release from the dull routine of home. A patient who early develops megrim headache without obvious precipitating factors may later react to every disagreeable situation, to every unpleasant piece of news, with headache.

"In all such cases, therefore, it is necessary besides reviewing the ordinary simple causes of headaches, to pay some attention to the personality of the patient, to possible sources of emotional conflict, to any trying situation to which the patient has to react."

"Even in cases where there is some fundamental difficulty with the individual system or organ the physician may realize that the disability of the patient is disproportionate to the organic involvement; the patient seems to refuse to get well, although everything seems to favor recovery. It is well then for the physician to consider what forces tend towards recovery, and what forces postpone it; to scrutinize the situation and to see whether there may not be a subtle gain from the invalidism. It may then be found that the sickness is a powerful weapon or useful crutch, and before the patient will honestly seek health a change of attitude towards fundamental life problems must be brought about. The true nature of these problems can, as a rule, only be understood after a thorough review of the personality of the patient and a study of the patient's reactions to the more important tests of life."

PSYCHIATRY AT THE FRONT IN THE AMERICAN ARMIES. By Major Mortimer W. Raynor. *The State Hospital Quarterly*, 4: 301–06, May 1919.

Major Raynor was divisional psychiatrist of the 79th Division from September, 1917, when it was organized at Camp Meade, until it was ordered home at the close of the year 1918. This address was based on his experiences for two months in the Argonne, the Troyon Sector and the Battle of the Meuse.

The duties of a divisional psychiatrist at the front are to keep up the fighting strength of the division and to eliminate promptly those who become unfit for duty; to examine and sort officers and men returning to advanced sanitary posts for exhaustion, concussion and neuroses; to treat the light cases, preserving as many as possible for duty; and to examine mentally prisoners and men suspected of having self-inflicted wounds.

The divisional psychiatrist during combat was stationed at the *triage*, or sorting station, which was as near the front as practicable. The sick and wounded were tagged either by the medical officer or an enlisted man of the regimental sanitary detachments, in a general way indicating that the man was wounded, gassed, sick or nervous. By using the term

"N.Y.D. (nervous)" for the latter group of cases, there was avoided any suggestion of "shell shock" or of their translating the term into a disorder recognized as incapacitating them. They were, therefore, open to the explanations of the medical officer that they were only tired or nervous.

The type of fighting determined to some extent the number of psychiatric cases. Open warfare with the men on the alert and moving forward produced fewer cases than when the fighting necessitated long periods of heavy bombardment with the men remaining in trenches or reserve positions. Artillery fire with the whistling of approaching shells, terrific detonations and terrible mutilations of comrades unnerved many men; whereas Major Raynor could not recall a single patient who referred to rifle or machine-gun fire as upsetting him.

Insufficient sleep, food and water, combined with days of constant fighting; were important factors in producing exhaustion. Fifty per cent of those evacuated as "gassed" were really fatigue and exhaustion cases. Of the medical cases reporting to the *triage* the most common diagnoses were bronchitis, influenza and diarrhea. In many cases the most important factor was fatigue. In the last group there were neuroses with tremors, speech and hearing disorders, ataxias, and stupors. The severe cases were evacuated to the advanced neuropsychiatric hospitals, while the milder ones were retained, treated and returned to duty.

True cases of concussion almost always asked to be returned promptly to their organization, which was allowed in the less severe cases. Aside from the milder cases of exhaustion sorted from the gassed and medical groups, the largest number of psychiatric cases were the exhausted with nervous symptoms. These were men who were worn out and unnerved by seeing comrades killed or injured or possibly by being knocked over themselves by a shell explosion. Major Raynor cited from his notes instances of this kind.

In treating these cases, field hospitals were operated under canvas, in old barracks or in partially destroyed buildings as near the *triage* as possible. The men were allowed to sleep as long as they wanted to and were given hot food and drinks. Medical cases were taken care of, and the patients were given a chance to relate what had happened to them. A brief neurological examination was made and they were told that they were tired and needed rest and food. The patients with tremors, speech disorders, etc., and those still tearful were isolated until the symptoms disappeared, as suggestion was a strong factor. Practically all these cases were returned to duty in from 24 to 96 hours.

Treatment within the division of the exhausted and milder nervous disorders, etc., discouraged the evacuation of large numbers of men. The fact that these conditions were not put on the same plane as wounds and also the fear of being considered "yellow" by their comrades influenced the men to "stick it out."

During the two months the 79th Division was at the front, the total losses were approximately 7,000, of which number 1,726 were diagnosed as gassed, 50 per cent of whom were cases of exhaustion. Approximately an equal number of medical cases were really exhaustions. There were 147 neuroses and true psychiatric cases, of whom 67 were evacuated and the rest treated and returned to duty. Four cases were evacuated a second time. There were 35 cases of "self-inflicted wounds," all of which were found to be accidental. A certain number of men were later found who had persistent nervous disorders. Many of these became apparent in the hospital after evacuation for some other cause.

In concluding, Major Raynor pays a tribute to the efficient manner in which Col. Thomas W. Salmon, M.C., Senior Consultant in Neuropsychiatry, organized, coordinated and directed this branch of the medical work with the army in France.

MALNUTRITION AND HEALTH EDUCATION. By David Mitchell. *The Pedagogical Seminary*, 26: 1–26, March 1919.

In February, 1918, the Bureau of Educational Experiments organized and held "nutrition classes" for about four months in Public School 64 in New York City. The children, 894 in number, were examined for height and weight, and where undernutrition was found, the cause was determined and an effort made to build the children up by establishing proper nourishment, rest periods and good habits, the removal, if necessary, of adenoids and tonsils, and the proper care of the teeth. Rest rooms and meals were provided in carrying out the experiment.

The children were divided into three groups: first, all who were seven per cent or more overweight; second, all those between seven per cent over- and seven per cent underweight; and third, all those seven per cent or more underweight. On the basis of the findings it may be concluded that 16.8 per cent of the entire school population are seven per cent or more under the weight which they should have for their height. In New York City this would mean that of the 1,000,000 school children 168,000 are undernourished. Among the children in the special classes studied, which comprised exceptionally bright children, 27.5 per cent were seven per cent or more underweight. In the "open air" classes, composed of children selected primarily because they were anæmic or because there was a history of tuberculosis in the family, only 28 per cent were seven per cent or more underweight.

The treatment given the 125 undernourished children in the nutrition classes, came under five general heads: (1) instruction in health habits; (2) removal of all physical defects that interfere with the processes of nutrition; (3) frequent periods of rest; (4) food given at frequent intervals rather than in larger quantities at infrequent intervals; (5) direct feeding—the provision of the actual food.

In making the arrangements for carrying out the experiment, the chief consideration was to determine the value of feeding compared with instruction in health habits. It was found that instruction in health habits was a very important factor. The children who received no instruction but were given a sufficiently large mid-day meal, gained only about one quarter of the amount expected of them during the time. The "open air" class gained only at about one half the rate expected, but their class was conducted under unfavorable conditions, the other children being present while the nutrition class was conducted. This was a constantly disturbing element. The result with the children in the special classes showed a total gain of 61.6 pounds for the 17 children. Their expected gain was 43.2 pounds for the period, giving a net gain of 18.4 pounds, almost 50 per cent more than the average expected gain.

Enlarged tonsils and adenoids apparently have a decided effect upon the nutrition of a child. An interesting table shows the per cent of gain of children before and after tonsil and adenoid operation. Other data are furnished with reference to the effect of carious teeth upon nutrition, but the numbers are too small to lead to any clear-cut conclusions. The figures suggest that the teeth may be in quite faulty condition without interfering with the process of digestion. Charts showing the records of individual children are also presented.

The report includes a mass of interesting data, and a table is presented, the use of which enables one to determine the average weight for any given height of a boy or a girl from two to sixteen years of age. This table is constructed on the basis of data furnished by Holt, Burk, and Boas.

The nutrition class works on the assumption that every child wants to be like other children. Various methods are used to promote the necessary competition. The problem must be met not alone by school feeding but also by an educational procedure. It is not sufficient to bring a child up to normal weight and leave him without habits which would enable him to continue in that condition. He must be educated in matters of personal health and hygiene, in the reasons for eliminating certain things, also the reasons for the observance of other things, such as proper amount of food, periods of rest and sleep, slow eating, etc.

The report presents the following conclusions:

1. Every child should be weighed and measured and those who are as much as seven per cent underweight for their height should be selected for nutrition classes.

2. Provision of food is not in itself adequate to solve the problem of malnutrition.

3. Habits such as rapid eating, using water as a flush, eating when excessively fatigued or irregularly, should be corrected.

4. Stimulants, such as tea and coffee, must be eliminated.

5. Physical defects, such as naso-pharyngeal obstructions, must be removed.

6. The amount of food should be carefully measured. A record of two consecutive days' consumption is a fairly reliable index for a week.

7. Rest and food should be given at not too long intervals. A mid-morning lunch and rest are needed by those children who are unable to store up a reserve of energy.

8. The nutrition class offers an opportunity for teaching many children hygiene and health habits. The competitive spirit is aroused. The chart shows actual gains or losses, and the children see the connection between these changes and the things that are spoken of as causes.

SURVEY OF PROVINCE OF MANITOBA, 1918. By the CANADIAN NATIONAL COMMITTEE FOR MENTAL HYGIENE.

In October, 1918, the Canadian National Committee for Mental Hygiene, at the request of the Public Welfare Commission of the Province of Manitoba, began a study of conditions in that province particularly with reference to hospitals for mental diseases and institutions caring for mental defectives. The investigation included a survey of the two hospitals for mental diseases, the Portage La Prairie Home for Incurables, the East Kildonan Home for Feebleminded Children, Stony Mountain Penitentiary, reformatories, gaols, institutions for dependent poor, institutions for normal children, primary schools, a visit to the Huetterite Colony at Bernard, examination of 50 consecutive cases appearing before Juvenile Court, examination of 50 consecutive cases appearing before Police Court, study of all legislation dealing with insane, feebleminded and epileptic, and study of medical education and provision made for psychiatry.

Facts brought forward by the survey were the number and location of the insane, feebleminded and epileptic in the province; the relationship of those outside suitable institutions to such problems as crime, juvenile delinquency, prostitution, illegitimacy, alcoholism, pauperism and unemployment; present methods of treatment; defects in present legislation dealing with them; proportion born outside Canada; efficacy of present methods in preventing mental disease and defect, crime, juvenile delinquency, prostitution, illegitimacy, alcoholism, pauperism and unemployment; and effect of the feebleminded upon primary school educational efficiency and school morals.

Among the recommendations presented by the Committee in concluding its report are the following:

1. That a commission responsible to the Province be developed and empowered to inspect, control and direct the activities of all institutions supported by government aid.

2. That the chronic insane be segregated in the hospital at Brandon.

3. That a farm colony be established to accommodate fifty male patients.

4. That the medical staff be of ample size and include a pathologist fully qualified in serology and bacteriology.

5. That every patient admitted be the subject of study and discussion at staff meetings, which should be held twice a week at least.

6. That the nursing staff be composed of qualified nurses of good education.

7. That a convalescent home be established near Winnipeg for complete restoration of patients before their discharge into the community.

8. That voluntary admissions be authorized.

9. That regular admissions be made upon the certificates of the properly qualified physicians after the superintendent of a hospital for mental diseases has made an examination of a preliminary form of history to be filled in by the physician in attendance.

10. That gaols as places of detention for dangerous insane be avoided.

11. That the federal authorities be asked to make a careful study of the problem of immigration and provide the proper remedies.

12. That two mental clinics for prevention and after-care be organized—an outdoor clinic attached to the Psychopathic Pavilion, and a clinic established in connection with the hospital for mental diseases at Brandon. The latter would act as an itinerant clinic.

13. That careful study of prisoners be made from the psychiatric and psychological points of view, to weed out the mental defectives and the mentally diseased.

14. That the feebleminded be segregated in suitable institutions of the farm colony type, with adequate provision for segregation according to sex, degree of mental defect, and reason for commitment.

15. That a special institution be provided for defective delinquents.

16. That all children attending the public schools receive a mental and physical examination at stated intervals.

17. That backward classes be used as observation centers and only such pupils retained as are found suitable for the specialized instruction and care afforded.

Report of the Maine Commission for the Feebleminded and of the Survey by The National Committee for Mental Hygiene, September 1, 1917—September 1, 1918.

In accordance with a resolution passed by the legislature of Maine in 1917, the Governor with the advice and consent of the Council, appointed a commission to make a "thorough and complete study of the feebleminded within the state and report with recommendations as to the future policy of the state." This commission was composed

of Ex-Chief Justice William P. Whitehouse, Augusta, Chairman; Rev. David N. Beach, Bangor; and Mrs. Marion D. Eaton, of Portland. This commission invited The National Committee for Mental Hygiene to furnish an expert to serve as secretary to the commission and as director of the survey. Dr. Guy G. Fernald was selected, who carried on the investigation for a year and prepared the report.

The tentative plan of the survey as outlined is as follows:

1. "A study of the laws of the state, pertaining to the care of those suffering from mental disease.

2. "A study of the facilities in the State of Maine for the care of the feebleminded.

   a. Public institutions
   b. Private institutions
   c. Special classes in public schools, etc.

3. "The gathering of the data from which it would be possible to prepare a reliable estimate of the number of the feebleminded in the state by an examination of

   a. Inmates in institutions, state hospitals for the insane, prisons, reformatories and other state institutions
   b. County and municipal institutions caring for the poor, misdemeanants and dependents
   c. The institutions and societies caring for children
   d. Private societies engaged in work for the poor and unfortunate, associated charities, Florence Crittendon Homes, etc.
   e. The examination of children in schools of the state to establish the amount of serious retardation and to determine approximately, at least, the number of these children who are definitely febeleminded.

4. "Such other local problems as seem important and for which there is time.

5. "The analysis and correlation of the data gathered in the above studies and the preparation of a constructive program."

"Since trained field investigators were not available and the time of the Director for making intensive mentality examinations and collecting data could not be extended beyond one year and since, moreover, the survey was preliminary and educative in its nature and purposes, an economic expenditure of expert energy dictated the utilization of information in the possession of intelligent and volunteer local observers, i.e., the town officials and professionally trained citizens.

"In seeking a basis for an estimate of the numbers of the feebleminded recourse was had, therefore, to those who know the members of the class in their own locality. The township was selected as the unit and town officers were solicited by preference, though in very many larger towns and in all cities an informal conference was arranged

at which a physician or teacher was usually present. In many towns, however, laymen's applications of our definition have furnished the estimates of numbers."

During the survey 162 cases were intensively studied and recorded. Returns were obtained from 164 cities, townships and plantations, and 121 institutions, including almshouses and jails. Estimates of the numbers of the feebleminded in these institutions were secured from local observers. Twelve rooms of public school children and four special groups were given congregate intelligence tests, and three degenerate communities were several times visited.

The intelligence tests used in the schoolrooms were those of Lyman F. Wells, Psychologist at McLean Hospital, Waverley, Massachusetts. "The tests used in our individual personality examinations were: (1) psychiatric tests adapted to the determination of the absence or presence and the varieties of mental diseases, (2) searches in the field of intelligence by means of the standard 'Terman Tests,' enabling a numerical valuation in terms of intelligence quotient and intelligence age level, supplemented or substituted in the case of adults by unstandardized tests which have been found of value in classifying mentalities of adults, and (3) searches in the field of character by the inductive method, since tests in this field, like those in the field of mental diseases, are not yet susceptible of numerical scoring."

From the studies made there were estimated to be 1,659 persons obviously feebleminded, their distribution being shown by the following table:

	Supported or helped by the town or state	*At large in the community*	*Total*	*Population represented*	*Number per thousand*
In urban districts of 2,500 or more	61	262	323	262,652	1.25
In rural towns of less than 2,500	112	145	257	167,130	1.54
Total	173	407	580	429,782	1.35
Estimated population of Maine				783,350	
Number per thousand, 1.35 applied to state's population			1,058	353,568	
In 121 special schools, hospitals, city and county almshouses, jails, etc.	601		601		
Grand total	774		1,659		2.12

The feebleminded in the institutions of Maine are shown by the following table:

Name of institution	*Population*	*Number of feebleminded*
Augusta State Hospital	1,018	80
Bangor State Hospital*	691	78
Eastern Maine Orphans' Home	...	..
Maine State Prison	200	2
Maine School for the Blind	31	1
Maine School for the Deaf	102	10
Maine School for the Feebleminded	262	262
Maine State School for Boys	135	15
Maine State School for Girls†	185	23
Woman's Reformatory	51	15
Fifteen city and county almshouses‡	205	33
Eighty other almshouses of known population show a prevalence computed on the ratio of the 15	350	56
Sixteen county jails	239	8
Total	3,469	583

Although 1,659, or 2.12 per thousand of the population, were obviously low-grade feebleminded, the report emphasizes the fact that this gives no indication of the number of high-grade feebleminded, the class which on the whole are the greater sociologic and economic menace. The cases of mental defect, deviation and other aberration found, did not differ essentially in kind or number from those of similar communities elsewhere. Maine was found unique in one regard as to population, however—the increase since 1850 has been much slower than that of the United States as a whole.

The great majority of Maine's feebleminded are scattered fairly evenly throughout the state in both cities and rural districts. They quarrel freely among themselves, show no inherent cohesiveness and, especially certain mill operatives, part-time laborers and domestics, drift from place to place.

Twelve teachers in various parts of the state informally reported backward or peculiar children, but none of them could be reached for examination. Some of these children are undoubtedly feebleminded and there are many who need training in a special class. But in one special class in a factory village the only difficulty was the foreign tongue and the language of the home. The State School Report for 1916 shows 165 boys and 157 girls in special classes in fourteen counties

* Excluding 19 constitutional inferiors.

† Only 65 doubtful cases were examined. Case summaries or abstracts of some of these are given.

‡ For the populations of almshouses not visited we are indebted to the *Fourth Annual Report of the State Board of Charities and Corrections.*

and in academies. The average daily school attendance for the state was 102,877.

There has been a failure in most of the towns to provide for school medical inspection. Some form of state organization for this purpose will undoubtedly be organized. The Commission suggests, before the corps of medical inspectors is organized, that public school medical examiners be affiliated with or directed by a state psychiatric staff so that guardians of doubtful cases would have the advantage of the best psychiatric advice early in the development of the child.

The importance of controlling the activities of the feebleminded is apparent. The state and city commissions appointed to investigate prostitution and the vices and diseases that go with it, report that from 50 to 80 per cent of prostitutes are feebleminded (including the higher grades of feeblemindedness). The unsupervised feebleminded girl is a grave menace, either potential or actual.

The propaganda in Maine for better mental hygiene in the field of feeblemindedness is a philanthropic sociologic movement for social uplift. Its method of realization is to suppress parenthood among the unfit and to supervise the activities of the feebleminded. The estimate is that 80 per cent of feeblemindedness is inherited. If attention is focused on this generation alone the prospects of diminishing the burden is small, but taking well considered steps now, before the end of another generation there should be a marked decrease in the number of feebleminded.

The Commission feels that if a judicial investigation by experts of the thinking capacity and responsibility of all criminal offenders were instituted and all mental defect were examined and registered, it would act as a deterrent to lawlessness and be very valuable, as offenders could be dealt with on the basis of their mentality as well as culpability.

The great need for the organization of psychiatric skill under state control has been indicated by the large number of applications received by the Director's office for diagnosis of mental defect and deviation. They came from physicians, officials, institution heads, charities and welfare societies and from parents and guardians. Most of the inquiries related to the disposal of cases. The need in Maine of a body of psychiatrists to determine borderline cases, to recommend treatment and to carry out sociologic projects is very apparent. The organization of a state board or commission would rouse a spirit of progress along these lines among young medical men and students.

Recourse to amendment of laws should not be considered until the public is receptive and ready to support the measures proposed. At present a small force of field workers should supervise the extra-institutional feebleminded, possibly one in each city and one in each rural district comparable in size to a county. These workers should be selected, trained and directed by a state staff of psychiatrists. The

state psychiatric staff or commission would be responsible for registering, diagnosticating and distributing cases and for making case records and studies from them.

The report gives comprehensive graphs of three degenerate communities, showing their consanguineous marriages and mental classifications. Each community graphed has been represented by a disproportionately large number of inmates of juvenile and penal institutions as well as jails and almshouses. In many instances child welfare agencies have found it best to separate children from their parents. One of the largest degenerate communities, that on Malagre Island, was dispersed by the state's taking over the island and annexing it to an adjoining town. The squatters were told to disperse. Three consignments of feebleminded children were sent to the State School for Feebleminded from this one island.

In addition to an account of the findings and recommendations for each institution investigated, statistical tables are presented with reference to four groups of abnormal persons intensively studied; data showing the distribution of the feebleminded in the community and in institutions; photographs of feebleminded in the community, their dwellings and surroundings; graphic presentations of degenerate communities; a number of case and family histories; and an appendix containing definitions of the types of mental defectives, an outline of mentality study and six bulletins issued by the Commission. The more immediate needs of the state and some of the machinery for supplying them are briefly stated in the following recommendations of the Commission:

1. "Education of the public on the problems of feeblemindedness and the means of solution, i.e., Maine citizens should know the numbers of the class and especially of the inimical, high-grade feebleminded, many of whom are potential offenders. They should know the cost of supporting these in idleness and vice on the one hand, and of training them in youth to economic usefulness on the other. Maine people should know the importance of detecting those of degenerate stocks whose progeny is most sure to be dependent, in order to plan for the elimination of these in the future. Maine people should be convinced that feeblemindedness in the community is a burden which may be humanely diminished.

2. "The extension of the mental clinic idea, now happily inaugurated in Maine, to the establishment of clinics in the other large cities at which guardians, judges and court officers, institution heads, physicians, teachers, and others may ascertain the mental status of those whose behavior suggests investigation.

3. "Provision for the enactment of a suitable commitment law, placing the control of all feebleminded in the hands of the state's experts,

so that those of both the intra- and the extra-institutional types may be appropriately treated.

4. "Extension of the State School for the Feebleminded and the Woman's Reformatory to twice or three times their present capacity in the attempt to relieve the communities of the intra-institutional feebleminded and inimical female offenders.

5. "Provision for the freest use by the courts of the findings of the state's alienists.

6. "Provision for more intensive teaching of psychiatry in the state's medical schools and for the teaching in the normal schools of the available means of securing a diagnosis of suspected cases of mental defect in children.

7. "Extension of medical inspection in the public schools to the early discovery of cases of mental defect, deviation and disease.

8. "Examination and classification of all inmates of penal and reformatory institutions.

9. "Provision for the inauguration of a continuing census of the state's feebleminded.

10. "A continuing voluntary association of competent citizens to organize research, to educate public opinion and to formulate measures for legislative enactment.

11. "State recognition of the psychiatrical resources of the state and the organization thereof for the examination, registration and supervision of the state's feebleminded."

BOOK REVIEWS

MORBID FEARS AND COMPULSIONS; THEIR PSYCHOLOGY AND PSYCHOANALYTIC TREATMENT. By H. W. Frink, M. D. New York: Moffat, Yard and Company, 1918. 568 p.

In this book Drs. Frink not only discusses the symptomatology and mechanisms of morbid fears, but he gives a long and careful review of the psychological mechanisms which are involved in the psychoneuroses. The author has been very much influenced by the writings of Freud, and accepts in detail the teachings of the latter, even when they are most hazardous and hypothetical. At the same time one finds the first suggestion of a *rapprochement* between two extreme modes of statement, an attempt at the formulation of the underlying truths of Freud's doctrines in terms which are in harmony with the rest of our biological and psychopathological knowledge. The author frequently puts side by side the conventional jargon (*sit venia verbo*) of the Freudian school, and a more familiar and intelligible formulation of the same facts. In many branches of science one must introduce a new terminology to do justice to new facts or to new conception of familiar facts, but there are certain general canons which should determine the nomenclature, and the acceptance of much excellent work has been retarded by its artificial phraseology. The author shows a certain sensitiveness to this situation, and the peculiar phraseology of the Freudian school is to a certain measure neutralized by the alternative formulation in ordinary English without too many terms derived from mythology. That the author has not shaken himself free from the Freudian tradition is seen in his description of the sensitiveness of an overconscientious clerk as due to "a certain measure of the narcissistic homosexual libido" failing of satisfaction, and regressing in the direction of earlier points of attachment.

The book has an introduction by Dr. James J. Putnam. The first five chapters (pages 1–270) are an exposition of Freudian psychopathology. The following five chapters are devoted to the topic which gives the title to the book. The last chapter gives the author's views of the factors which are involved in the cure or lack of cure by means of the psychoanalytic treatment.

The book is very long because the author takes great pains to make his thought clear; he has used numerous examples to illustrate his points; he has not hesitated to repeat when necessary. Such a detailed exposition will be very welcome, for condensation involves much labor to the reader and is, after all, no true economy. Chapter seven (pages 308–430) gives a case in great detail. The elaborate interpretations in this case are, as always in similar cases, open to some criticism, but the general presentation is clear and one can follow easily the mechanisms which the author emphasizes.

The book is a welcome contribution to psychoanalytic literature, and is all the more so because it is free from any attempt to dazzle by means of daring new hypotheses without foundation. It should be a great help in stripping the excellent work of the Freudian school of some of its exotic coverings, thus making it more suitable for assimilation with the findings of other schools of psychology and psychopathology.

C. MACFIE CAMPBELL.

CLINICAL STUDIES IN FEEBLEMINDEDNESS. By Edgar A. Doll. Boston: Richard G. Badger, 1917. 232 p.

The outstanding merit of this little book lies in the detailed reports of case histories in feeblemindedness. These case histories, of which there are six, concern a potentially feebleminded individual, a potentially normal, a neurotic or psychopathic deaf-mute not feebleminded, a psychopath with slight intellectual retardation not amounting to feeblemindedness, and a high-grade borderline immigrant, offering very convincing clinical proof of the diagnostic value of the Binet-Simon measuring scale of intelligence which, by the way, no one who understands feeblemindedness is inclined to question. The psychometricians, however, still seem to feel the need of mustering evidence in proof of this contention, especially when it serves to delimit the place of the study of feeblemindedness within the field of medicine.

Doll, for instance, finds it necessary to state, "We positively disclaim any intimation that a physician or medical specialist is not qualified to diagnose feeblemindedness. Except for a small minority of cases, our whole contention is that such a person cannot do so by the medical data directly."

Inasmuch as the earliest studies in this field were carried on by medical practitioners, and that essentially and from the practical point of view, feeblemindedness must be looked upon as a type of pathological human behavior (a problem in medicine), we doubt the necessity of such concessions as Doll makes.

A greater willingness on the part of the psychometricians to see the neurologist's and psychiatrist's points of view might open their eyes to the fact that no well equipped and well conducted hospital for the treatment of disordered human conduct ignores the value of psychometry as a diagnostic instrument.

Has not the time arrived when our psychologists might devote more time and effort to a clarification of the subject of mental deficiency, in which we are all interested, instead of wasting so much time in telling the physician what his sphere of professional interest should be?

The glossary of terms and bibliography ought to be of value to those interested in the subject of feeblemindedness.

BERNARD GLUECK.

THE PSYCHONEUROSES OF THE WAR. By G. Roussy and J. Lhermitte. London: University of London Press, 1918. 177 p.

This short book, translated by Wilfred B. Christopherson, is first of all useful to and intended for those actually engaged in the handling and care of soldiers suffering from nervous and mental disorders. It aims to be entirely faithful to observed fact and in a large measure it is so. The authors have their own doctrine which in general follows that of Babinski. But they are not controversial. They cling closely to actual observation, though not to the detriment of the point of view they hold.

The book deals primarily with the psychoneuroses of war. Indirectly it treats also of conditions with which the psychoneuroses may be confused or contrasted. The result is a well defined, clearly constructed monograph free, on one hand from too great didactic detail and, on the other, richly suggestive without being vague or doctrinaire. The text deals painstakingly with motor disorders, paralyses, contractures, disorders of gait, tremors, tics and with psychical disturbances of sensation. The portion of the book dealing with the latter is especially well done. The visceral disorders are treated briefly and as a transition to the discussion of psychical disorders. The authors deal also briefly with attacks of terror and motor agitation. The discussion follows the textbook form of description and diagnosis, with liberal attention to differential features such as the man on the run finds useful. Excellent summaries conclude each section. There are also numerous photographs of psychomotor disorders with very adequate legends.

The psychical disorders arising in relation to the war receive admirable treatment. It is not the least the merit of this discussion that the authors make of it a background for the concluding descriptive chapter which deals with the matter of concussion. They clearly tease out the organic etiological factors and effects from those of psychogenic nature with open fair-mindedness. The etiological considerations are summarized in a final chapter in what might be regarded as too brief a manner. Especial emphasis is laid on the prevalence of psychopathic constitution and on alcohol. The rôle of emotion is very hastily dealt with in this connection. The chapter on treatment adds essentially nothing to what is already well known to any one who has followed with even casual interest the current literature of the war neuroses. The bpok contains at the end a few pages on the psychoneuroses and military decisions.

The book must be set down as excellent and adequate for the purpose for which it is written. It is confessedly a summary. Reference to specific cases is lacking. With time it is to be hoped that the authors may publish detailed studies of cases to which those who are interested in more detailed study of the psychoneuroses may refer.

G. S. AMSDEN.

FUNDAMENTALS OF CHILD STUDY; A DISCUSSION OF INSTINCTS AND OTHER FACTORS IN HUMAN DEVELOPMENT WITH PRACTICAL APPLICATIONS. By Edwin A. Kirkpatrick. New York: The Macmillan Company, 1917. 380 p.

This is a department-store type of book. It brings together in one volume, in the most convenient form possible, a vast amount of useful information regarding child development. There is great need for such books and the demand for *Fundamentals of Child Study* has brought it to a third edition.

It has not escaped the fault of the general-purpose type of book, for it gives the reader a greater sense of confidence in the conclusiveness of the information presented than the facts of science justify. Since the book will undoubtedly become the very gospel of educational practice for many teachers, it is unfortunate Kirkpatrick did not give the book that suggestion of something-more-to-know which marks the most skilful and useful book of this kind. Teachers and parents surely need open minds as much as they need systematized satisfaction. If the references suggested by the author are read this sense of security will, of course, dissolve rapidly but many will be satisfied with the text and will leave the book ill prepared to appreciate how alien to the facts is any suggestion of finality with reference to such a problem as that of human instincts.

Psychologically the book is orthodox and the reader is not given even a glimpse of the claims staked by the Freudians which they consider so rich in the ore of child understanding. All Freudians, and others beside, will regret that a book going into the hands of the average teacher and parent states that fear in the milder forms may be made a useful motive in child development (page 134).

The book has a full bibliography but it is lacking in very recent citations, especially those in the field of abnormal psychology. The book will prove of value to few readers of MENTAL HYGIENE.

ERNEST R. GROVES.

THE PSYCHOLOGY OF MARRIAGE. By Walter M. Gallichan. New York: F. A. Stokes, 1918. 300 p.

This belongs to that ever multiplying brand of book which we are compelled to label "not genuine psychology, only psychology plated." Literature of a quasi-scientific character has the habit of wandering over the surface of the department of thought whose title it appropriates, culling the names of a few writers for incidental reference and then launching forth into a miscellany of information on the plan of a Baedecker. This volume is no exception. Its sincere purpose is that of guidebook to the understanding of the problems of premarital and conjugal life. It is apparently addressed to English readers, who still need elementary counsels upon sexual physiology, hygiene and ethics. Its sentimental presentation of these subjects can hardly appeal to the alert American

student, married or unmarried, by whom experimental findings in the field of sex psychology are beginning to be known.

Such statements as the following stamp the book instantly with its inherent weakness: "If a suitor's handgrasp or kiss does not whisper of heaven to a woman's heart, he is not the lover of her natural desire." "It should be known that the desire of the sexes for one another is not an automatic physiological impulse, but chiefly and normally a profound wish born in the brain and associated with the tenderest and most beneficent emotions in all instances of truly fervent love. The seat of this physical and emotional feeling is in the cortex of the brain and its manifestation is often against the will of the individual."

Notwithstanding copious quotations from a wide range of writers, the author's bibliography on psychology of sex appears to begin and end with Freud, Hall, and Ellis. Nowhere is there a reference to sound experimental works on differential psychology or even a grasp of fundamental principles. He claims that the girl is by original tendency more modest and more subject to revulsions than her brother. Scientific psychologists have not determined such a sex difference. He talks of the three stages of marriage—"the capture, purchase and contract." The hypothesis that capture was instinctive at the time and that the resistance of woman in love is still instinctive is psychologically untenable because it is based on the assumption that woman is by original nature opposed to the sexual relation. Again, the tendency to dominate is present in every normal individual and we find no warrant for the declaration here that woman is primarily desirous for man to dominate her physically.

Mr. Gallichan's social psychology is inconsistent with current theories of the original nature of man and oblivious to the present status of measurement of sex differences. Furthermore, he shows lack of acquaintance with the trend of contemporary biological science as well. One example of this is his position on the so-called transmission of "racial poisons" through the germ plasm. Indeed his entire treatment of the venereal problem is naïve.

His exposition of the eugenic program is sane and clear sighted. There is a wealth of advice worthy of unhesitating approbation and hence it may seem a bit ungracious to point out the foregoing flaws. They will not be detected by the lay reader but the student cannot seriously regard it as an authoritative contribution. MIRIAM C. GOULD.

MENTAL CONFLICTS AND MISCONDUCT. By William Healy, M.D. Boston: Little, Brown & Company, 1917. 330 p.

The thesis of the book is stated in the first lines of the introduction: "A remarkable dynamic quality characterizing certain hidden mental reactions to experiences is responsible in some individuals for the pro-

duction of misconduct, or, indeed, whole careers of delinquency." The author has found that a study of the physical development and family history and inquiry into environmental conditions are insufficient in certain cases of abnormal behavior. In one thousand cases of youthful recidivists, there were seventy-three cases where mental conflict was the main cause of the delinquencies.

The first four chapters of the book are given over to a description of analysis, which is termed "mental analysis" in preference to psychoanalysis. In the presentation one finds the familiar terms, conflict, repression, conversion, substitution, etc., but in the real material of the book which follows there is little application made of the technical terms, and the author states that in his investigation he found little necessity for using dream analysis or invoking symbolism. The forty cases which form the body of the book are extremely interesting and convincing because they are presented in a simple direct manner. The majority of individuals studied were children and in the cases presented the vital experiences are given in the child's own words, which need no elaborate interpretation. The material is divided under various chapter headings: *Conflicts Accompanied by Obsessive Imagery, Conflicts Causing Impelling Ideas, Criminal Careers Developed from Conflicts*, etc., but in the main the problems which led to the investigation were, stealing in a great number of instances, running away from home, lying, disobedience, irritability, bad temper, "malicious mischief," etc. It was most frequently the case that the child had had some unfortunate sex experience or had acquired from the person responsible for the change in his reaction and habits sex knowledge that stimulated ruminations and cravings which he secretly combated. Very often the children in relating their experiences speak of the headache which they suffer when they think of the tabooed word or recall the suggestive pictures. One is tempted to speculate why it is that a neurosis does not develop. It may be because children do not tend to lapse readily into invalidism, and have greater freedom than adults in expressing tension and unrest as misbehavior in varying forms. In the final chapter the author raises the question whether mental conflict represents a reaction that implies a peculiar constitution, and inquires to what extent misdoers through mental conflict are neurotic. He also discusses the problem of heredity, age of onset of the conflict, length of time a conflict may lie dormant, special mental traits, general abilities, the results of special tests, etc. Healy is unable to satisfy his own inquiry about the complete normality or abnormality in reaction type of those who develop mental conflicts. The desire for finality and nicety of distinction tends to create artificial standards and one is relieved to find that the author emphasizes the peculiar settings in which the experiences occur, the lack of opportunity for ventilation of the conflicts and the absence of sympathetic guidance.

A. Scott.

PSYCHOLOGICAL TESTS; REVISED AND CLASSIFIED BIBLIOGRAPHY. By David Mitchell and Georgie J. Ruger. New York: Bureau of Educational Experiments, 1918. 116 p. (Bulletin 9)

The compilation of the above bibliography of mental tests, and the present revision, will be of special value to all who are interested in the growth and extension of the fields of mental testing. It is perhaps better suited to the uses of the expert than as a guide for those who are able to spend considerable time in this special field. Some method of indicating treatises and final summaries, perhaps under a separate section, would enable the non-expert to keep up his acquaintance with the principal lines of progress.

The total numbered items are 1428. Many articles are repeated in different sections, so that the actual total is nowhere indicated. It is presumed that when the bibliography of "articles of earlier date" is completed this method will be changed so that the quantitative growth can be noted.

Four pages are devoted to an enumeration of tests by name, together with names of authors reporting on the tests. It is somewhat difficult to determine why the authors decided names of certain tests should appear and others be omitted.

This and other previous efforts to list tests by name suggest interesting possibilities. There is no apparent reason why names may not continue to multiply. Perhaps it is not too early to suggest that the selection of some mechanical system of classification would be greeted with enthusiasm by the compilers of bibliographies. It is conceivably the just procedure, since no single author would care to accept the responsibility of offering an "intrinsic" classification.

CLARENCE S. YOAKUM.

SCHOOL ORGANIZATION AND THE INDIVIDUAL CHILD; GRADING AND SPECIAL SCHOOLS. By W. H. Holmes. Worcester: The Davis Press, 1912. 142 p.

The school, according to Holmes, should simplify its course of study in the fundamentals to insure its completion by every normal child. It can then allow the bright pupil to do intensive work. If individual instruction supplements class work, the advantages of the old ungraded school may be regained.

Special schools for subnormal children provide a means of detecting the feebleminded in need of institutional care. Quoting such authorities as Goddard, Tredgold and Havelock Ellis, the author stresses the dangers created by the feebleminded at large in the community. He records the Binet-Simon mental tests with comments and criticisms by Terman, Kuhlmann and others. The Terman Revision of the Binet-Simon tests had not yet appeared.

After-care of the special-school pupil receives merited prominence at the hands of Holmes.

Although there is little original material in the book, it is valuable as a popular presentation of the question of segregation *versus* sterilization of the feebleminded adolescent.

ERNEST R. GROVES.

HEREDITY AND ENVIRONMENT IN THE DEVELOPMENT OF MAN. By Edwin Grant Conklin. Princeton: Princeton University Press, 1918. 550 p.

Professor Conklin has presented in brief form the essential general facts concerning physical and mental development of organisms and has traced the cellular basis of development and of heredity. He discusses rather fully the phenomena of inheritance and describes the principal achievements in the experimental studies of that subject during the past eighteen years. He points out briefly general facts concerning modification of development by environment and in two final chapters discusses the improvements of cultivated plants, domesticated animals and man, and also the relation of genetics to ethics.

For readers of MENTAL HYGIENE Conklin's position on eugenics is especially to the point. As a biologist Conklin has no doubt at all about the universal importance of heredity in relation to society and in determining the qualities of individual men. When it comes to the matter of determinism and responsibility Conklin is inclined to take a middle ground. The middle of the road is generally regarded as the safest course but in the present instance one cannot help feeling that Conklin's conclusions on this subject are influenced by non-biological considerations. He says (p. 482): "Freedom is the more or less limited capacity of the highest organisms to inhibit instinctive and non-rational acts by intellectual and rational stimuli and to regulate behavior in the light of past experience." Freedom, thus defined, is as Conklin suggests of a limited sort. One wonders if freedom is really not more limited than even this cautious sentence implies. Inhibition of instincts is itself an instinct, as we see indeed in dogs, as for instance in the retriever which brings back the delicate bird without biting it. Inhibitions can indeed be cultivated when the germs of them are present, but if the germs are not present then the individual can not inhibit. The capacity for inhibitions may be quite as automatic and as instinctive as the instinct itself.

Of the literary and mechanical characteristics of the book one can speak only in the highest praise. Professor Conklin is an extraordinarily clear and attractive writer and the book is well printed and convenient to handle. It is an excellent introduction to the subject of human heredity.

CHARLES B. DAVENPORT.

SYPHILIS AND PUBLIC HEALTH. By Lieut.-Col. Edward B. Vedder, M. C., U. S. A. Philadelphia: Lea and Febiger, 1918. 315 p.

Colonel Vedder's studies in the epidemiology of syphilis, well known to syphilographers in this country, have culminated logically in the notable contribution to technical syphilology and the science of public health represented by the book whose title appears above. The work makes an immediate impression as a scholarly and singularly complete presentation of a subject now crossing a new threshold of world interest and world enlightenment.

The book includes an introduction setting forth the importance of syphilis as a public health problem and a factor in mortality; a remarkable chapter on the prevalence of syphilis; chapters on each of the following subjects: sources of infection and methods of transmission, personal prophylaxis, public health measures; and an appendix detailing a Wassermann technic, citations from special laws and systems of control including the West Australian, and an index of authors and subjects.

The first chapter, a monograph in itself embracing 108 pages and citing in its bibliography 143 titles, is a monumental contribution of permanent value to the literature. Much more than this, it is an arsenal of effective weapons for those who are engaged in bringing home to an as yet unawakened public intelligence, the tremendous significance of syphilis for the future of the race and its overwhelming importance among the public health problems of today. It enables the individual syphilographer, the public health officer, the lecturer, to replace vague and untrustworthy personal estimates and experience with a mass of detailed information whose exactness is a matter of surprise even to the more than casual student of the problem. This feature of the work alone makes it an indispensable reference.

The chapter dealing with the sources of infection and the transmission of the disease is also replete with valuable statistical material. The problems are succinctly stated and the experimental evidence underlying modern conceptions is well, though perhaps a little too briefly, set forth. It is inevitable that in a work destined for the general medical and perhaps lay public the discussion of such problems as maternal infection and the paternal transmission of syphilis should be curtailed, although the syphilographer cannot but regret that Colonel Vedder did not feel it advisable to bring his scholarly mode of attack to bear upon this much mooted subject.

Personal prophylaxis is discussed with the same completeness that characterizes the whole work. The *résumé* of the literature on the effect of circumcision as a preventative and the history of mechanical and chemical prophylaxis is replete with interesting detail. The standard set for the marriage of syphilitics is commendably conservative though not extreme. A momentary confusion is introduced by the earlier mention of

the spinal fluid examination and its apparent omission in the final modification of the Finger standard.

In his discussion of the sociological background of syphilis in the problem of sexual promiscuity and prostitution, Colonel Vedder indulges in a frank but tempered and well balanced pessimism. His direct appeal to efficient treatment as the main hope of prophylactic endeavor is well timed, and places a satisfying emphasis upon the rudimentary character of existing facilities and upon the reduction of the cost of treatment by abolition of private monopoly of arsphenamine. The appendix supplies a variety of technical details of value. While perhaps not strictly within the province of a work of this type, one cannot but wish that a minimum treatment standard had been given, since such a *résumé* would be of much use in a book certain to have a wide professional reading and an authoritative place in the literature. One cannot escape, too, the wish that Colonel Vedder had reviewed the relation of syphilis to industrial compensation and to health examination and insurance with the same completeness with which he has dealt with other aspects of the subject. While knowledge of these issues is still in its infancy, anything which he had felt willing to contribute would have had an eager hearing.

Critical comment on Colonel Vedder's book can deal only with minor details. The work is in every particular a remarkable one, certain to be widely read, and in the best sense, expressive of the erudition and exceptional experience of an authority.

JOHN H. STOKES.

THE PSYCHOLOGY OF BEHAVIOR. By Elizabeth Severn. New York: Dodd, Mead & Company, 1917. 349 p.

This book contains considerable everyday psychology, but its title should be the metaphysics of behavior rather than the psychology of behavior. It ignores the scientific studies of behavior in animals and men and the author herself distinctly states, "The viewpoint is frankly metaphysical rather than biological, and idealistic and suggestive rather than materialistic and positive." She adds, however, "Yet sight has not been lost of the need of exactitude where it is so easy to be vague, and emphasis has been placed upon the *governing principles* of human conduct rather than upon its particular phases."

The author reports extended experience in the practice of psychotherapy, and the book is largely based on such experience. It presents a fairly good outline of important facts in regard to feeling and emotion, and contains many suggestive paragraphs, but the exactitude claimed by the author is liable to be suspected by the reader, since the fundamental methods of science, upon which all exactitude must rest,—first-hand observation, experimentation and verification—are given up at the outset, and metaphysics invoked. The author's observation, however,

is better than her point of view, and the common-sense observations and concrete phenomena reported are helpful.

The value of this book lies in the clear statement of some of the more common everyday facts of psychology and certain practical suggestions in mental hygiene, together with a good discussion of certain simple psychological and hygienic principles from the point of view of psychoanalysis. But the reader should not accept too literally some of the statements in regard to the mental processes. The writer says, for example, "We can perform no act that we have not previously been able to visualize" (p. 125). This ignores the imaginal differences as seen in those whose dominant imagery is motor, auditory, or vocal motor. Again, "broadly speaking, emotions may be divided and usually are into the two general groups of pleasure and pain." While pleasure is to be reckoned among the feelings, its opposite is displeasure rather than pain; and pain is, as modern investigation has shown, a sensation. It is unfortunate that a writer on psychology should not refer to the rich literature of comparative and human psychology; and to write on human behavior without regard to the investigations of Stanley Hall, Thorndike, Watson, Yerkes, and the other scientific workers in this field, is to give inevitably a one-sided, imperfect, and erroneous account.

Since this book is intended for the general reader, it might be said that as a contribution to psychology it is inaccurate and as a handbook on human behavior it is inadequate; but if the reader should label it *aspects of behavior from the point of view of a worker in psychotherapy*, then it would prove helpful, and contribute many practical suggestions presented in a pleasing and interesting style.

WILLIAM H. BURNHAM.

MEDICAL DISEASES OF THE WAR. 2d ed. By Arthur F. Hurst, M.D. (Oxon.), F. R. C. P., Temporary Major, R. A. M. C. London: Edward Arnold, 1918. 319 p.

The book is a revision of a work by the same author published in 1916. The chapter on *War Neuroses* has been expanded into eleven in the present edition. It is precisely these chapters dealing largely with hysteria that are neurologically of the greatest interest.

The contents of these eleven chapters are:

1. Predisposing Causes.
2. Exhaustion Resulting in Neurasthenia and Soldier's Heart.
3. Neuroses Resulting from Emotions.
   a. Stupor and Amnesia.
   b. Psychasthenia.
   c. Hysteria.
   d. Hyperadrenalism and Hyperthyroidism.
   e. Exaggerated Defensive Reflexes.

4. Shell Shock.
   a. Pure Concussion.
   b. Spinal Concussion.
   c. Hysterical Symptoms Grafted on to Organic Basis of Concussion.
5. Conditions Predisposing to the Development of Special Symptoms.
   a. Epilepsy.
   b. Mental Disorders.
   c. Tabes, General Paralysis and Cerebral Syphilis.
   d. Disease or Injury of a Limb.
   e. Past Emotional Disturbances. Psycho-analysis.
6. Motor Disorders.
   a. Hysterical Paralysis, Attitudes and Gaits.
   b. Tremor.
   c. Hysterical Contracture.
   d. Reflex Paralysis and Contracture.
   e. Hysterical Fits.
7. Disorders of Speech.
8. Disorders of Hearing.
9. Disorders of Vision.
10. Hysterical Pain.
11. The War and Organic Nervous Disease.

The writer agrees with Babinski's definition that hysterical symptoms result from suggestion on the part of the patient himself or on the part of somebody else, and that they are curable by persuasion and suggestion acting alone. He states: "There is no such thing as hysteria apart from hysterical symptoms. It might be supposed that the underlying mental condition which makes an individual liable to develop hysterical symptoms is hysteria, but there is no mental condition of this kind constantly present, as nobody is free from liability to develop hysterical symptoms if the suggestion is sufficiently strong."

The following are interesting extracts from the different chapters. "It is very rare for hysterical symptoms to develop actually in the trenches—. . . . In the dazed condition which results from prolonged mental strain the man is abnormally suggestible; his critical faculties are lost and his initiative is diminished. As he gradually comes to himself he tends to exaggerate and perpetuate the difficulties he experienced in the performance of the various functions of his body. The absence of movement due to absence of initiative leads to the suggestion of paralysis; the silence due to absence of any stimulus to speak in his con-

fused mental condition suggests mutism, and the inattention, which prevents his hearing what is said to him, suggests deafness."

"It is essential for success in treatment that the medical officer should feel convinced that the patient's symptoms are not organic or are at most only in part organic. . . . Whatever treatment is employed, the encouragement produced by the presence of cured patients to those about to be treated is mostly helpful. . . . An atmosphere of cure in which the medical officer, the sisters and the recovered patients in the wards all play their part is of the greatest value for newcomers, however long they may have been ill before admission. . . . The patient is also made to understand that there is nothing unusual about his case. The extreme interest and sympathy with which he is surrounded account for the frequent persistence of hysterical symptoms for many months spent in some luxurious hospital. . . . Simple persuasion followed when necessary by re-education is all that is required to cure most hysterical symptoms. . . . Electricity is useless unless employed solely as a means of suggestion. . . . Electricity is particularly harmful when any tremor is present."

"Hypnotism is useful in the treatment of psychasthenia but it is generally not the most satisfactory means of treating hysterical symptoms."

"The term 'shell shock' should be reserved for the condition which follows exposure to the forces generated by the explosion of powerful shells in the absence of any visible injury to the head or spine."

"Hysterical tremor is very common and is due to the perpetuation by auto-suggestion of the tremor caused by fear."

"Hysterical fits are much more common in soldiers than might have been expected from their rarity among men in civil life. The idea of convulsions may be already present in a man's mind if he has previously suffered from true epilepsy, or if he has been the witness of convulsions in some near relation: horror or fright may then suggest an attack. The diagnosis of hysterical from true epileptic fits has generally to be made from the patient's own account of his attacks. A true history of involuntary micturition or of injury to the tongue caused by biting are the only points suggesting true epilepsy. A man rarely if ever has an hysterical fit when he is by himself; if his companions say that he has struggled with them, or clutched at objects near him, the fits are certainly hysterical. . . . The only signs which can be regarded as conclusive evidence against hysteria are definite cyanosis, complete loss of conjunctival and corneal reflexes, loss of the pupillary reaction to light and most conclusive of all an extensor plantar reflex tested as soon as the convulsions have ceased and before consciousness has returned. In cases of doubt I have tried to induce an attack by suggestion under hypnosis. In hysteria a fit is generally produced at once. . . . I always combine this method of diagnosis with treatment by telling the

patient before, during and after the fit that this one will be the last he will ever have. The treatment has proved most successful."

"The majority of cases of hysterical aphonia which I have seen in soldiers followed laryngitis. . . . Hysterical aphonia generally recovers after the application of a sound, or in more severe cases, of faradism, to the interior of the larynx."

The author's discussion of the pathogenesis of hysterical deafness on page 118 is interesting because he definitely postulates an organic change in the central nervous system for this condition. "In hysterical deafness the patient is so convinced that he cannot hear that he does not listen. Although the sound vibrations reach the ear in the normal way, they do not give rise to the slightest auditory sensation because of this inattention. The synapses at one or more of the cell-stations in the auditory path to the cerebral cortex must, therefore, be unswitched, probably as a result of retraction of the dendrons. In absolute hysterical deafness the auditory motor reflex, which is a function of the mid-brain, may be abolished or greatly diminished. One of the unswitched synapses must, therefore, be below the mid-brain and either in the auditory nucleus or less probably in one of the intermediate cell-stations—the superior olive or the nucleus of the lateral fillet." Suggestions, therefore, produce an unswitching of the synapses which can be cured by suggestion or persuasion. Surely this is an interesting theory.

H. A. Reye.

Libraries of the American State and National Institutions for Defectives, Dependents and Delinquents. By Florence Rising Curtis, M.A. Minneapolis: University of Minnesota, 1918. 56 p. (Studies in the Social Sciences 13)

Miss Curtis, in this brief yet comprehensive study of her subject, has made a real contribution to the cause of mental therapeutics as well as to the understanding of this most important but perhaps not generally known phase of special library work—institution libraries. Probably not many librarians even are acquainted with the development of this phase of library work which has taken place almost entirely within the last fifteen years.

The writer introduces her subject with a brief historical sketch of state and national institutions, and outlines the inherent problems of employment, education and recreation for inmates.

In Chapter II, she discusses the place of the library in the various types of institutions. "The advocate of the insane hospitals," says Miss Curtis, "will meet several objections from those who have not given the subject careful attention. These objections are usually three: first, that the insane through the nature of their affliction are mentally incapable of receiving any real benefit from books; second, that so many are disturbed and violent that books will not be safe in their hands; and,

thirdly, that a library is an unnecessary fad, purchased at considerable expense for those whose comfort and well-being are in no way dependent on its use."

In refuting the first of these objections, Miss Curtis quotes statistics to show that many patients suffering from mental disease are by no means illiterate nor lacking in the ability to appreciate literature and art. Probably one fifth of all admissions are cases of manic-depressive insanity, which is periodic in nature, with, frequently, long intervals of mental health. This type of patient is very dependent upon reading for relief from depression and for the purpose of taking his mind off himself. Nearly a quarter of all cases admitted suffer from dementia praecox, the mental disease of the adolescent and of the young adult. Many of these patients have been youths of unusual intelligence and promise. In such cases occupational and educational interests may prevent complete dementia. Reeducation is now a feature in the care and treatment of patients in some institutions for the mentally diseased. It has been found that nature study makes an especially direct appeal and has proved very beneficial because it trains the observation and affords the student outdoor exercise. Needless to say, books on birds, flowers and trees aid greatly in arousing and holding the interest of the patient in the subject.

In refutation of the second objection—that patients are likely to mutilate or destroy books—Miss Curtis quotes statements by authorities to the contrary. Many hospitals record a careful handling of books of which any public library would be proud.

To refute the third objection—that money used for such libraries is an unjustifiable expenditure—the writer bases her argument upon the records and statistics of various institutions, from statements of institution librarians, attendants and physicians and from letters of patients—the most convincing evidence that the institution library plays a very important rôle, not only as a form of recreation, but also as a remedial agent. Dr. Max Witte, superintendent of the state hospital at Clarinda, Iowa, says: "If we should be permitted to come back in one hundred years, no doubt we should find the librarian acting under the direction of a physician and occupying a very important position in the treatment of the insane, more particularly in the earlier forms of insanity. . . . ."

Books in institutions for mental defectives are, needless to say, largely juvenile fiction and fairy tales, with some travel and biography for the more intelligent, and picture books for those of more limited mental ability.

In institutions for juvenile delinquents books are a veritable saving grace. Many a young scapegoat has had his interest in questionable escapades and bad companions diverted to wholesome sports, inventions or nature study by the proper kind of reading. To the wayward girl an interest in books often becomes a pleasure and also a protection, the latter especially if she is thrown upon her own

resources, when the public library affords not only recreation but a refuge from temptation and the advances of undesirable associates.

Statistics compiled from the records of reformatory and prison libraries, of institutions for inebriates, the tuberculous, dependent children, the blind, the deaf and the disabled, of homes for soldiers and sailors and their wives and widows all testify to the importance and value of well-organized, well-equipped and efficiently administered libraries.

Miss Curtis next outlines the history of the movement for state supervision of institution libraries, from 1905, when the first concerted effort for efficient service was made by the Board of Control and the superintendents of the various institutions of Iowa. Up to this time, some institutions had possessed book collections, a few of which had been classified and catalogued. In 1897 the New York State Library had published a list of books for the libraries of institutions for the mentally diseased. This was followed by the publication in 1917 of the first section of a list of books for prison libraries. In 1913, the Minnesota Board of Control created the position of Supervisor of Institution Libraries. Nebraska was the next state to take this step. In several other states the library commissions or similar agencies assume the supervision of institution libraries. The institution libraries of Indiana are testimonials to the efficacy of such a system when properly administered.

The administration of the institution library is discussed from three points of view: the book collection and the book fund, the library room, and the library service. This chapter is full of valuable suggestions for the institution librarian.

Chapter V traces the activities of library associations in regard to institution libraries, from the appointment in 1908 by the League of Library Commissions of a Committee on Library Work in State Institutions through the recent work of the American Library Association, which has included a survey of institution libraries in the United States, various publications, and the making of a collection of pictures of institution libraries to be used at state charities and corrections conferences and as a reference collection to be loaned to superintendents or others interested.

The last chapter in the book treats of the future development of the institution library. Miss Curtis presupposes that such a library will always be under the board of control, the library commission or a similar agency. "If placed under the library commission, the work has the advantage of continuity with the other library interests of the state: the executive officer of the commission is alive to the possibility of further service and the connection promises permanency, a cooperation in the use of books and other collections, and the influence of accepted standards in regard to records and equipment. On the other hand, if the institutions have been placed under the board of control it would seem

that the supervision of the institution libraries might well be considered the duty of an officer of the board; in either case, there should be a supervisor, whose authority should come from the board of control.

"Realizing the special problem of the institutions, the superintendents in Iowa, in 1905, and again in 1911, urged the selection of a woman for the office. The reformatory and the prison are the only institutions where a different choice might be urged; experience has shown that the solution lies in the appointment of a woman of maturity and judgment, as well as education and training, and experience in her chosen field. In order to secure such an incumbent of the office, the salary paid should range from $1,500 to $2,000 per annum. Both economy and efficiency would be increased if suitable headquarters were furnished and the work was centralized. . . . This plan would presuppose office room and clerical and other assistance when necessary.

"The library of such institutions should be a separate department, recognized in the budget by a regular annual appropriation, and the statistics of its growth and use included in the annual report of the superintendent. There should be a minimum of 1,000 volumes for each institution."

A comprehensive bibliography follows the text of the monograph.

In the preface of Miss Curtis' pamphlet, written by Arthur J. Todd, Professor of Sociology in the University of Minnesota, the following statement is a just tribute to the value and importance of the monograph. Professor Todd says: "In publishing Miss Curtis' study of institution libraries, I am sure the University of Minnesota is rendering a notable service, not only to libraries and institutions, but also to the general public which is still shockingly ignorant of how its institutions are really administered. This little volume stands unique in its field, as it brings together a large amount of first-hand material secured through original research, in addition to collating scattered papers on single phases of the problem. It administers a definite refutation to the popular fallacy that institution libraries are a fad and that inmates of such institutions cannot and will not make use of them."

MABEL W. BROWN.

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